COUNTY COUNCIL OF CUMBERLAND

Annual Report

ON THE

HEALTH SERVICES OF THE COUNTY

For the Year 1949

KENNETH FRASER,
M.D., F.R.S.E., D.P.H., D.T.M.,
COUNTY MEDICAL OFFICER

INDEX

	Page
Agency Arrangements	87
Cancer	68
Dental Services	57
Housing	81
Infantile Mortality	13
Infectious Diseases	70
Laboratory Services	89
Milk	75
National Health Service Act, 1946:—	
Section 21 (Health Centres)	17
„ 22 (Care of Mothers and Young Children)	25
„ 23 (Midwives Service)	27
„ 24 (Health Visiting)	30
„ 25 (Home Nursing)	31
„ 26 (Vaccination & Immunisation) ...	32
„ 27 (Ambulance & Sitting-case Car Service	33
„ 28 (Prevention of Illness, Care and After-care)	40
„ 29 (Home and Domestic Help) ...	41
„ 51 (Mental Health Service) ...	45
Orthopædic Treatment	60
Tuberculosis	53
Venereal Diseases	63
Vital Statistics	10
Water Supplies and Sewerage	85
Welfare Services	91

TO THE CHAIRMAN AND MEMBERS OF THE CUMBERLAND COUNTY COUNCIL

MR. CHAIRMAN, MY LORD, LADIES AND GENTLEMEN,

I beg to present the annual report on the Health Services of the County for 1949. The vital statistics for the year do not call for any comments other than those made in the appropriate sections of this report.

It has been my custom year by year to take the opportunity in this introduction to the annual report to refer to various points of special interest which merit your attention. On this occasion I propose to refer to one matter only which is in my view of such outstanding importance that it overshadows everything else.

Can the Health Services as an integral part of Local Government survive?

In my last report I wrote with some anxiety about the future prospects of health departments in their efforts to maintain an efficient health service under the influence of several new factors, the chief of which was the passing of the National Health Service Act of 1946. During the intervening months this anxiety, which I believe is shared by many other medical officers of health, has increased. I am not, I trust, an alarmist, but every thinking person with the interests of the public health service at heart cannot fail to be alarmed at the present position and the present trend. It will not, I think, be disputed by anyone, indeed it cannot be disputed, that the continuance of an efficient local government health service (including a school health service), must depend, in the first instance, upon an adequate recruitment of young medical graduates who propose to make the public health service their profession. The plain truth is that this recruitment does not exist. The post-graduate schools, I understand, have only a fraction of the candidates for the Diploma in Public Health, or corresponding qualification, who used to present themselves. One university held no post-graduate course in public health last year, and the position is likely to be repeated this year because of the lack of applications. Even among those young practitioners who sit for the diploma only a proportion, I believe a small proportion, are training to enter the public health service in

this country. Many of the students are not of British nationality or are going overseas for one reason or another.

What is the cause? It may be:—

(1) The meagre scales of salaries offered by local authorities which do not compare favourably, in fact do not compare at all, with the remuneration offered in other branches of medicine. In this connection the inordinate delay in getting to grips with this matter is deeply to be regretted, and is causing much resentment in the service. There is supposed to be a standstill order affecting all salaries and wages in the country. This order is only partial in its application. It applies to some groups. It does not apply to others. If proof is needed I refer to the salaries of dental technicians, which under Whitley Council circular P.T.B.2, were substantially increased in September, 1949, with effect from 1st May, 1949, and to the salaries of mental health workers who have just been regraded by a National Joint Council decision with effect from 1st April, 1950.

I do not imagine that any group of workers in the country has received less justice in recent years in this matter of balancing salaries against the rising costs of living than assistant medical officers of one kind or another in the employment of local health authorities. The last adjustment of salaries of assistant medical officers at the lowest end of the scale took place with effect from 1st July, 1947, and amounted to the raising of the salary, with a maximum *to be attained after* 8 *years of service, by* £25. *That was not an increase. It was an insult.* The first essential in attracting medical recruits to the public health service is to pay them a living wage, and unless recruits are attracted the public health service cannot continue to function.

(2) Another possible cause for the falling off of recruits for vacancies in the local health medical service may well be that the service has lost much of its attractiveness through the operation of the National Health Service Act. There was a time, some 40 years ago, when the work was little more attractive than it is now. It was in the main confined to the *ascertainment of defects,* particularly among school children, but those who went into the service then were optimists. They felt that the situation and the interest

would develop and expand, and their optimism was justified by results.

The assistant medical officer became the friend and adviser of large groups of people, the tuberculous, the expectant mothers, the head teachers, the parents of children of school age and of pre-school age. He was kept in touch with all important developments in connection with these groups of cases in this county and I suppose in most counties by the headquarters department. He could meet patients, parents and teachers, with up-to-date information, *and with something to say.* He could advise on problems affecting the pre-school life of the child, the school life, or the choice of a career. Health departments, if our own experience was typical, were clearing houses for thousands of problems affecting individual health annually. Now most of this has gone. As I said last year, the assistant school medical officer has "lost face." As one of them said to me the other day, "Nowadays we know nothing about anything. People who have asked us questions over the years which we could answer, now ask us the same questions, and we cannot answer them. We have become cyphers." Recent events have, in fact, put the clock back 40 years.

It is probably because of the widespread dissatisfaction over this state of affairs that the Ministry have issued a directive to Regional Hospital Boards and Hospital Management Committees (H.M.C. (50) 21), from which I quote:—

> "*Adult patients needing after-care following discharge from Hospital.*
>
> It is generally agreed that the family doctor should have early information of the discharge of a patient from a hospital and should make arrangements with the Local Health Authority for service such as home nursing, domestic help, etc. There are, however, cases where direct information, including any necessary medical details, should pass from the hospital to the Local Health Authority, in order to avoid a break in the services provided, e.g., in the provision of special nursing requisites for paraplegics, or more simply to arrange for immediate home nursing attention or domestic help. Such arrangements should, of course, only be made with the patient's agreement and the family doctor should be informed that

arrangements have been made direct with the Local Health Authority. A form agreed regionally for transmission of this information would be useful.

In maternity cases where either the local health authority's and/or ante-natal clinics have supervised the patient prior to hospital admission, information regarding treatment and any abnormal occurrence should be supplied to the Medical Officer of Health of the Local Health Authority on the patient's discharge from hospital. Advance information should, of course, be given whenever a maternity case is discharged early and requires care through the Local Health Authority service.

Children.

The joint responsibility of the family doctor and the Medical Officer of Health or School Medical Officer is recognised and it is suggested that the same information should be sent to the family doctor, and, for a school child, to the School Medical Officer, or for a child under school age, to the Medical Officer of Health of the County or County Borough in which the child lives. The arrangement may most conveniently apply to all children of school age or below and should include information on the discharge of babies born in hospital, especially premature births, necessary details of feeding in such cases and deaths of children in hospital. If it is possible information about premature babies should be sent before their discharge. The form signed by the parent on the child's admission to hospital should include a note intimating that, in the absence of a request to the contrary, information sent to the doctor will also be sent to the School Medical Officer or Medical Officer of Health of the Local Health Authority unless the parents object.

In addition to applying to all children discharged from hospital following in-patient treatment, the arrangement for the supply of information should be extended to cover children who have attended as out-patients in those cases where the information would be of value."

We must see that this directive is implemented. I understand that the reaction of Hospital Management

Committees over the country has been diverse. Some take the view that the work involved—and admittedly this is considerable—is not justified. That view is just not tenable. In this county we have received a great deal of information from the East Cumberland Hospitals. From the West Cumberland Hospitals, except in respect of midwifery, we have received little or none. I could give plenty of examples to demonstrate the value of this information from hospitals to us as a Local Health Authority still with some statutory responsibilities in respect of such groups as expectant mothers, tuberculous persons, school children, and pre-school children. The value to the hospitals, and to the patients, of co-operation between the parties is equally apparent. We have just got to see that it happens. *It will be absurd if the hospitals and the local health authorities work in water-tight compartments.*

Many suggestions have been made from different quarters that more of the services still administered by local health authorities should be transferred to Regional Hospital Boards. This suggestion has been made in connection with the school health service, with domiciliary midwifery, with the ambulance and sitting case car service, with pædiatrics (care of young children) and in connection with other matters. If such transfers should take place from local control to Regional Hospital Boards or to any other body, the position would be greatly worsened; it would, in fact, become impossible. The local government health services would become even less attractive to young graduates as a profession than they have now become; the salt would indeed have lost its savour.

I am quite certain that Regional Hospital Boards have neither the wish nor the machinery to take over services like those quoted. Look at some figures for this small county for 1949:—

Number of journeys undertaken by ambulances and sitting case cars ...	20,861
Clinic attendances	33,685
Domiciliary midwifery nurses' visits ...	19,618
Nurses' visits to children under 5 years ...	66,335
Domiciliary ante-natal examinations ...	2,764

These are only a few typical figures. The sooner it is realised that services of this kind can only be administered locally the better, and the sooner the trend to press for the transfer of services from local to departmental control, whether on financial or any other grounds, is halted, the better. *Remote control simply will not work.*

Some people seem to think that the gaps which have appeared in the local government health services in recent years can be filled by turning attention to health propaganda, health education and what is vaguely called socio-medicine. I think people who hold this view are visionaries. I cannot see such nebulous things as health propaganda and socio-medicine attracting men with guts into public health as a profession.

I have written at some length about the position as it affects the recruitment of assistant medical officers, but the situation in respect of other key positions is very nearly as difficult. It certainly is as far as this county is concerned, and I know that it is so in other areas, but whether the position is general throughout the country I do not know. I suspect that to a large extent it is. Without going into details which are merely of local interest one can say that with regard to the filling of vacancies in the assistant dental staff it seems to be a waste of time to advertise. With reference to vacancies in the posts of psychiatric social workers, orthopædic physiotherapists, and speech therapists, the position is very similar. These long names put into simple words mean respectively persons to work in our child guidance clinics, persons to look after our cripples, and persons to deal with speech defects among the school children. These are all important matters, and we have been trying to find candidates to fill our vacancies for many months through the usual advertisement channels, and through many other means of approach, with, throughout the year, no result at all. In connection with two posts we have now received what appear to be firm applications, but the general experience has been that even if we do get *enquiries*, and these for all the posts mentioned could have been counted on the fingers of one hand over two years, these enquiries are not followed up by *applications*, and if there is a definite application the candidate tends to lay down conditions as to salary, and demands time,

amounting in some cases to six months, to make up his or her mind.

With regard to nurses, as I have pointed out elsewhere, we get practically no applications for the post of health visitors, and no response to our offer of training scholarships, and with regard to district nurses and midwives we have with very great difficulty just managed to keep our heads above water.

So the game goes on, and it must be clear to everyone that no service can continue to function under these conditions. Some people have expressed, and are expressing, the opinion that views such as I have outlined are defeatist. I cannot see anything defeatist in facing plain facts. The alternative is to imitate the ostrich and bury one's head in the sand.

Thanks.

I have again to express my thanks to the Chairman and members of the Health Committee, and the various sub-committees, for their continued interest and support throughout the year, and to all the members of the staff of the department who continue to give loyal and efficient service to the Council.

I am,

Your obedient Servant,

KENNETH FRASER,

County Medical Officer.

County Health Department,
11, Portland Square,
Carlisle.
July, 1950.

STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

The essential vital statistics for the year 1949 are as under:—

Population

	At 1931 Census.	Estimated by Registrar General, Mid. 1949.
Urban Districts	114,459 ...	85,080
Rural District	91,331 ...	127,090
Administrative County	205,790 ...	212,170

Population of Sanitary Districts, 1949

Urban Districts.		
Workington	28,900	
Whitehaven	23,690	
Maryport	12,200	
Penrith	10.410	
Cockermouth	5,230	
Keswick	4,650	
		85,080
Rural Districts.		
Border	28,850	
Ennerdale	29,120	
Wigton	23,000	
Cockermouth	19,540	
Millom	12,670	
Penrith	11,610	
Alston	2,300	
		127,090
Total for Administrative County ...		212,170

Rateable Value and sum represented by a penny rate

The rateable value of the County at 1st April, 1949, was £1,026,559. The estimated product of a penny rate was £3919.

Extracts from vital statistics for the year 1949

LIVE BIRTHS.

	Total Births.	Males.	Females.
Legitimate	3,719 ...	1,906 ...	1,813
Illegitimate	201 ...	96 ...	105
Total	3,920 ...	2,002 ...	1,918

Birth Rate per 1,000 population 18.5
(England and Wales 16.7)

STILL BIRTHS.

	Total Still-Births.	Males.	Females
Legitimate	101 ...	55 ...	46
Illegitimate	9 ...	4 ...	5
Total	110 ...	59 ...	51

Rate of Still-Births per 1,000 total birth 27.

DEATHS.

Total Deaths.	Males.	Females.
2,711	1,386	1,325

Crude Death Rate per 1,000 population 12.8
(England and Wales 11.7)

DEATHS FROM DISEASES AND ACCIDENTS OF PREGNANCY AND CHILDBIRTH.

From Sepsis	1
Other Causes	6

Maternal Death Rate per 1,000 Total Births—1·74.

DEATH RATE OF INFANTS UNDER ONE YEAR OF AGE.

All Infants per 1,000 Live Births	34
Legitimate Infants per 1,000 Legitimate Live Births	33
Illegitimate Infants per 1,000 Illegitimate Live Births	45

DEATHS FROM CANCER (ALL AGES) 383

DEATHS FROM MEASLES (ALL AGES) 5

DEATHS FROM WHOOPING COUGH (ALL AGES) 8

DEATHS FROM DIARRHOEA (UNDER 2 YEARS) 10

The 3,920 live-births were distributed among the Urban and Rural Districts as follows:—

Births, 1949

Urban Districts	Total Births.	Legitimate.	Illegitimate.	Birth Rate.
Cockermouth	87	80	7	16.6
Keswick	59	56	3	12.7
Maryport	238	226	12	19.5
Penrith	181	169	12	17.4
Whitehaven	512	491	21	21.6
Workington	524	507	17	18.1
Aggregate of Urban Districts	1,601	1,529	72	18.8
Rural Districts.				
Alston	31	30	1	13.5
Border	518	478	40	17.9
Cockermouth	337	322	15	17.2
Ennerdale	566	548	18	19·4
Millom	240	220	20	18.9
Penrith	202	193	9	17.4
Wigton	425	399	26	18.5
Aggregate of Rural Districts	2,319	2,190	129	18.2

The 2,711 deaths were distributed among the Urban and Rural Districts, as follows:—

Deaths, 1949

Urban Districts.	Total.	Males.	Females.	Crude Death Rate.
Cockermouth	71	35	36	13.6
Keswick	68	33	35	14.6
Maryport	154	88	66	12.6
Penrith	168	98	70	16.1
Whitehaven	302	142	160	12.7
Workington	376	204	172	13.0
Aggregate of Urban Districts	1,139	600	539	13.4
Rural Districts.				
Alston	33	20	13	14.3
Border	357	171	186	12.4
Cockermouth	239	120	119	12.2
Ennerdale	349	183	166	12.0
Millom	172	79	93	13.6
Penrith	143	73	70	12.3
Wigton	279	140	139	12.1
Aggregate of Rural Districts	1,572	786	786	12.4

Causes of Death

	No. of Deaths 1948	1949
Heart Disease	743	873
Inter-cranial Lesions (Cerebral Haemorrhage, etc.)	277	345
Other Circulatory Diseases	103	99
Cancer, Malignant Disease	356	383
Congenital Debility, Premature Birth, etc.	93	85
Pulmonary Tuberculosis	116	107
Other Tuberculous Disease	15	25
Pneumonia (all forms)	67	70
Other Respiratory Diseases	31	46
Deaths by Violence (including Suicide)	53	87
Acute and Chronic Nephritis	45	61
Bronchitis	82	92
Diabetes	19	16
Influenza	9	17
Digestive Diseases	83	73
All other causes	338	311
Road Traffic Accidents	12	21

The above tables of statistics show that there has been a fall in the birth rate from 19.4 to 18.5, and a rise in the death rate from 11.7 to 12.8 These trends are consistent with what has happened in the country as a

whole. The total number of deaths has risen from 2,442 to 2,711, which seems a surprising rise.. Deaths from heart disease and allied conditions have, as shown above, risen by something like 200, and this appears to be the principal cause of the variation. Deaths from cancer have climbed to a new high level. Apart from these points, the above tables call for little comment.

Infantile Mortality

Of the 3,920 live births during the year, 133 infants died before reaching the age of 12 months. The infant death-rate per thousand live births is 34 compared with 37 for 1948. The figure for England and Wales is 32.

Causes of Death.	No. of Deaths 1948	1949
Bronchitis	2	5
Debility, Congenital, Premature Birth, etc.	*87	†78
Digestive Diseases—Other	4	—
Diarrhoea, etc.	10	8
Whooping Cough	3	6
Diphtheria	—	—
Influenza	1	—
Measles	2	3
Pneumonia (all forms)	31	21
Tuberculosis—Non-pulmonary	—	—
Tuberculosis—Pulmonary	—	—
Violence—Deaths by	1	—
Other Defined Diseases	8	12
	149	133

* Includes 27 premature births.
† Includes 28 premature births.

The infantile mortality rate has again fallen to a new low level at 34 deaths per thousand live births.

Reference is made elsewhere in this report to the question of deaths in children born prematurely.

The distribution of deaths by sanitary districts is shown in the following table:—

Urban Districts.	No. of Infant Deaths.	Rate.
Maryport	10	42.0
Whitehaven	23	44.9
Penrith	7	38.7
Workington	25	47.7
Cockermouth	2	23.0
Keswick	1	16.9
Aggregate of Urban Districts	68	42.5
Rural Districts.		
Millom	6	25.0
Cockermouth	3	8.9
Alston	3	96.8
Wigton	16	37.6
Ennerdale	20	35.3
Border	13	25.1
Penrith	4	19.8
Aggregate of Rural Districts	65	28.0

1949 Rate for England and Wales ... 32

1949 Rate for Cumberland County ... 34

NATIONAL HEALTH SERVICE ACT, 1946

Part III.

Section 21—Health Centres.

The Nursing Services.

Section 22—Care of Mothers and Young Children.

Section 23—Midwives Service.

Section 24—Health Visiting.

Section 25—Home Nursing.

Section 26—Vaccination and Immunisation.

Section 27—Ambulance Service.

Section 28—Prevention of Illness, Care and Aftercare.

Section 29—Home and Domestic Help.

Part V.

Section 51—Mental Health Service.

SECTION 21

Health Centres

There is little, if anything, new to report under this heading. The departmental committee which was sitting when last year's report was written has not yet published its recommendations, or at least these have not been transmitted to local health authorities. I do not know what is happening in other parts of the country on this matter. I presume sites are being earmarked for possible health centres. At the moment, however, this part of the Act seems to have fallen into the background, no doubt, I imagine, on account of building priorities being required for housing and other more urgent matters. So recently as the 23rd March, in reply to a parliamentary question, the Minister indicated that one new building is under construction, and that one other building and one adaptation have been approved, and that other schemes are under consideration.

If this is the position in the country generally including London, and the large provincial towns, it will, I think, be a very long time before we see health centres established in this county. A committee has been set up to consider the questions of health centres and expansion of existing clinic facilities, which matters, at least in the larger urban areas, may be interlocked, and it has been decided to reserve two sites each in Workington and Whitehaven for the possible provision, at some future date, of health centres.

The first meeting of the committee was attended by a representative from the Regional Office of the Ministry, and the next step will presumably be consultations with the Cumberland Executive Council, and with the practitioners and local authorities in the areas concerned. Frankly, at the moment, we are very much in the dark as to what it is desirable to do in this matter, and as to what it may be practicable to do within any foreseeable time.

THE NURSING SERVICES.

Section 22—Care of Mothers and Young Children.

Section 23—Midwives Service.

Section 24—Health Visiting.

Section 25—Home Nursing.

Last year I attempted to write this report under separate sectional headings (Sections 22-25 inclusive), but there was necessarily much repetition because, after all, these sections deal mainly with nursing, and the nursing services interlock at so many points that the appropriate comments are to a large extent interchangeable. This year, therefore, I propose to write under a general heading of "The Nursing Services," and to include the statistics and certain other items under the sectional headings.

The outstanding event of the year was the decision taken in December, 1949, by the Cumberland Nursing Association to terminate the agency arrangement with the County Council, whereby the Nursing Association undertook on our behalf the midwifery and home nursing services, and to a large extent the health visiting. Some 50 district nurses are engaged in health visiting in areas not covered by the whole-time health visiting staff, such nurses acting as health visitors under temporary approval from year to year by the Ministry until the time arrives, if it ever does, when the county (a) will be fully covered by a staff of whole-time health visitors as envisaged in our proposals, or (b) until the district nurses are all state registered nurses with the health visitor's qualification.

The agency arrangement between the County Council and the Cumberland Nursing Association terminated on 31st March, 1950. At the moment of writing there remains the agency arrangement with the Penrith Nursing Association, the termination of which I think is desirable, because, owing to the establishment of the maternity home at Penrith, the amount of domiciliary midwifery in the urban district has fallen to a low figure, and the obvious set-up in Penrith is that there should be two district nurse midwives co-operating and relieving each other.

The termination of the work of the Cumberland Nursing Association is a matter of the first importance, and one which cannot be lightly passed over. At the time of its demise the Cumberland Nursing Association

had operated the domiciliary nursing services in the county almost exclusively for a period of 52 years. The history of the earlier years of the Association is of considerable interest, and I am permitted to make reference to this history by quoting from the early minutes of the Association. Some of the interesting points were the subject of reference by Lady Graham, the retiring President, at the closing meeting of the Association.

The Cumberland Nursing Association was started in October, 1897, the year of Queen Victoria's Diamond Jubilee, and was linked immediately with the Queen Victoria's Jubilee Institute for Nurses which had been founded ten years previously out of funds presented to the Queen on the 50th year of her reign, which funds she allocated to the establishment of a national district nursing service. A provisional committee was appointed under the presidency of the late Lady Mabel Howard, and from small beginnings rapidly covered the greater part of the county with a system of district nursing. An examination of the minutes shows that the organisation of this service was in very capable hands, and foreshadowed with a high degree of anticipation the requirements of district nursing.

Admittedly the set-up was primitive by to-day's standards. The first Superintendent, according to the minutes, went over the county "measuring districts by the cyclometer, and so marking what would be suitable centres for nurses." Village nurses, as they were called, were largely trained at the expense of the Association, "thus being practically equipped by the Association with a paying profession for life." The "paying profession" was not very lucrative because the salary was to be "not less than 12/- per week." Apparently the nurses as well as the superintendent, in addition to domiciliary nursing, assisted at major operations, which apparently took place in the homes of the patients. The uniform would hardly be acceptable to-day, and included among other things the right, during the summer months, to substitute for the official bonnet a sailor hat with a blue, white and red ribbon band. In winter those nurses who possessed cycles—apparently not many—were ordered to wear "a strong serge skirt over the washing one, which must be slipped off before any surgical or maternity case is attended to."

From these primitive beginnings there emerged, under wise leadership, a service which for over half

a century proved of immense value to the community, and especially to the poorer sections of the community. Lady Mabel Howard remained throughout a notable leader of the County Nursing Association's work, and had nearly completed 50 years' continuous service as president or secretary at the time of her death. While remembering the great services she rendered as the head of the organisation, it would be ungracious not also to think gratefully of the vast amount of voluntary work undertaken by the office-holders and members of the local nursing association committees. These officers and local committees not only kept the service running at a high level of efficiency, but by great and sustained labour year by year raised large sums of money by voluntary effort right down almost to the wind-up of the Association, thereby very substantially saving the public pocket. For quite a long time now these voluntary efforts have produced annually in the region of £11,000. Nor, must one forget to recognise with gratitude, as one has tried to do in previous reports, the work of the district nurses who, for very many years, on meagre salaries with no prospect of any pension, or at least of any adequate pension, inadequately housed, and travelling about their quite large districts in all weathers day and night on foot or on bicycles, maintained a service of which they can be justly proud. *As a remunerative profession there was nothing in it. As a vocation it stood at the highest level.*

The termination of the work of the Cumberland Nursing Association has coincided with the establishment of a trust fund to be called the Nurses' Benevolent Fund, the purpose of which is to make provision out of the accrued funds of the individual nursing associations and of those of the central body, for the payment to elderly retired nurses who cannot now, on account of their age, be brought into the Council's superannuation scheme, of gratuities or off-the-pattern pensions, or otherwise to assist these nurses financially in their retirement. That the object of this trust will command general approval is certain. The nurses in the age group concerned have had to work hard, and often under very trying conditions in the service of our people in Cumberland, with salaries which, in retrospect, seem little short of scandalous. It is pleasing to record that practically every nursing association in the county has placed its funds and other assets at the disposal of the Nurses' Benevolent Fund, and it is hoped that a total

of not far short of £40,000 will be available for the benefit of the nurses concerned.

The moving spirit in the formation of this trust fund has been Mr. Butcher, the Administrative Officer of this department, who, since the death of Lady Mabel Howard, has undertaken the duties of Honorary Secretary of the Cumberland Nursing Association. The work he has put into the administration of the affairs of the Association, and latterly into the organisation of the fund, has been very great indeed, and at times has seemed to impinge upon his normal duties in this department. The future, however, will clearly show that this time has been well spent, because, now that we directly administer the nursing services, the experience and knowledge he has gained will be of the utmost value.

Much time and much hard work have also been given to the Association and to the trust fund by Mr. Williams, Assistant County Treasurer, and here too the past links should be of great value for the future.

Co-operation between the Association and the Council has always been close, perhaps especially at the time when Lady Mabel Howard was both Honorary Secretary of the Association and Chairman of the County Health Committee. The Clerk, County Treasurer, and the County Medical Officer have, for many years, been members of the Executive Committee of the Association. All this means that as the Council assumes direct control of the nursing services it does so with the benefit of a large amount of acquired knowledge and experience.

Among the assets of the nursing associations, which will be transferred to the Council by purchase are some 34 cars, some houses, a certain amount of furniture, and some equipment.

With regard to cars, the position to-day is that out of 75 district nurses and district nurse midwives, 63 are provided with cars, the great majority owned by the County Council, but a few owned by the nurses themselves, and the remainder of the nurses are working in urban districts where motor transport has not hitherto appeared to be necessary, or are working in pairs sharing a car.

The quantity of transport owned by this department is now substantial, and with ambulances and the cars used by the administrative nursing staff, the total

number of vehicles involved is not far short of 100. This must raise at an early date the desirability of the establishment of some central repair and overhaul depot (or depots) in the county for this substantial number of vehicles. Obviously the day-to-day servicing and maintenance must be done locally, but major overhauls ought, I think, to be carried out at one or more central depots, at which depots also there could be garaged reserve ambulances and cars so that work may be carried on without interruption when vehicles are called in for overhaul or repair. No doubt other departments of the Council would also benefit from the establishment of such repair and overhaul depots, because the number of vehicles owned by the Council must now be very substantial indeed.

A number of rather antiquated cars used by district nurses have in the past year been replaced by new vehicles obtained under the priority arrangements of the Ministry. The provision of cars for district nurse midwives and midwives is a matter which causes us no anxiety. What does cause anxiety is the replacement of cars used by the administrative nursing staff and the health visitors, some of which are now over ten years old, and, although orders have been placed to cover the necessary replacements three times over, there is not the slightest sign or indication that any of these cars will be available for years. Transport in a county like this is absolutely essential for health visiting, and for the administrative supervision of the nursing services, and it would seem to be only commonsense that the priority existing in respect of midwives should be extended to other branches of nursing. This delay in the replacement of worn-out cars also affects the assistant medical and dental staff. Some doctors on my staff have been waiting for replacements for nearly five years, and all approaches on their behalf seem to bring one up against a stone wall. It is rather galling in these circumstances to see persons in other walks of life who seem to have been able to negotiate for new cars several times within the same period.

Turning now to houses, this matter has been given prolonged consideration, and the general position is set out in the housing section of this report, where it will be seen that a three-stage plan has been approved by the Council for the building, either directly by the Council or indirectly by the housing authorities on behalf of the Council, of houses for nurses at many points in the county. These houses, some of which will

house two nurses and some one, will be three-bedroomed houses with, in most cases, a small surgery and waiting room attached, and with a garage for one or more cars as the case may be. There is no doubt that action by the Council in this matter of housing should, in the years ahead, greatly facilitate the recruitment of nurses to the area.

In the matter of equipment, a general overhaul was undertaken during the year in respect of minor equipment used more or less day to day by the nurses. "Minor equipment" mean things like bed-pans, rubber sheeting, inhalers, feeding cups, etc. All this has been brought up to date. In the matter of major equipment —wheel chairs, air beds, rubber mattresses, etc.— negotiations have been in progress with the St. John's Ambulance Brigade and the British Red Cross Society, and authority has been given for the establishment of one depot at Maryport, and for the establishment of two or three depots, the location of which is at present under discussion, in other parts of the county.

The recruitment position in the various grades (health visitors, whole-time midwives, district nurses, district nurse midwives) has remained much the same. We have just managed to fill vacancies with a scramble and with practically no choice of applicants. As regards health visitors, we advertised several times during the year without eliciting any response. With regard to district nurses and district nurse midwives, we have managed to fill vacancies, but, as far as I can see, we are as far as ever from reaching, or even starting to reach, the target for health visitors set out in our "Proposals," and for adequate relief staff for the district nurse-midwife service. I do not know if our experience is general throughout the country, but I imagine it is, except possibly in a few favoured areas, and I imagine that the lack of response in respect of health visitors, district nurses and district nurse midwives may be due to the delay in readjusting their salary scales. Everyone knows that the salary position in nursing to-day is chaotic, and at the moment nurses seem to be tending to enter the hospital service rather than the local health authority service. It is very much to be hoped that the negotiations now in progress will not take too long to mature.

It is a disappointing to have to record that we only received two applications during the year for the training of nurses in health visiting under the Council's scheme for the grant of scholarships for this purpose.

Here again repeated advertisements have produced little or no result.

The arrangement previously operated by the Cumberland Nursing Association for district training under the Queen's Institute scheme will, of course, be taken over by the Authority, which has joined the membership of the Queen's Institute. Post-graduate training of nurses in the various groups has continued as before. Our sort of general target is that about 10 per cent. of the nurses in all groups are sent away for post-graduate training annually. In addition, so far as the midwives are concerned, regular monthly meetings are held of the East and West Cumberland branches of the Royal College of Midwives, and at most of these meetings lectures are given by specialists on appropriate subjects.

We have been asked during the past 18 months or so to take part in certain national investigations initiated by the Royal College of Obstetricians, the Nuffield Provincial Hospitals Trust, and the Society of Medical Officers of Health. These investigations, which are often extremely detailed, involve, in a rural county like this, a great deal of work, but I feel that it is right that we should play our part in national investigations of this kind, and I know that these efforts have been appreciated.

During the year a third Assistant Superintendent Nursing Officer was appointed.

Perhaps a word here is appropriate about the link-up between the nursing services and the home help service. Reference is made to this under Section 29, but it is worth repeating here that the link-up has proved efficient, not unduly burdensome, and has not shown any tendency to interfere with the nursing duties either of the administrative staff or of those working in the field, which duties, of course, must necessarily have priority.

The Superintendent Nursing Officer and her staff paid during the year 415 special visits in connection wth nursing matters. About half of these, as noted under Section 23, were in connection with the midwifery service, the balance being concerned with general nursing and health visiting.

As noted elsewhere in this report, a nursing sub-committee has been established by the Council to deal with the transferred services. The committee is to consist of ten members of the Health Committee, two external members, and four co-opted members to be

recommended to the Selection Committee by the Cumberland Nursing Association. The sub-committee will meet quarterly, or more often if necessary, for the following purposes:—

(a) To receive reports as to changes in the nursing staff of the County Council (health visitors, school nurses, domiciliary midwives, district nurse midwives) and quarterly reports from the Superintendent Nursing Officer.

(b) To deal with the following matters:—

(i) General supervision of the nursing services, including day to day administration with power to act.

(ii) Matters of discipline, with power to act.

(iii) Applications for scholarships under the Council's scheme for the training of health visitors, with power to act.

(iv) To make arrangements for training (including post-graduate courses) in health visiting, district nursing and midwifery services (gas and air analgesia, etc.), with power to act.

(v) To make arrangements for the provision of uniform and laundry arrangements, with power to act.

(vi) To make recommendations with regard to housing for nurses (including furnishings); the provision of garages; replacement of motor cars; regulations for the use of cars by district nurses for private purposes; and the provision of telephones.

(vii) To arrange for the maintenance of equipment required by nurses, and the provision of any necessary additional equipment, with power to act.

(viii) To deal with any other matters which may be referred to the sub-committee from time to time.

SECTION 22.

Care of Mothers and Young Children.

The statistics for the year are as under:—

Number of child welfare clinics	16
Number of children under one year of age attending	1,926
Number of children between 1-5 years of age attending	1,410
Number of attendances	...15,411
*Defects treated	184

(* Eye defects 107, ear, nose and throat defects 77. Dental and orthopædic are given elsewhere.)

The above is the general background in respect of the care of infants and toddlers. To these figures, of course, must be added large numbers of home visits by health visitors, dealt with under Section 24, and large numbers of attendances at clinics.

With regard to illegitimate children, 90 cases were investigated, and in only 10 of these was there any

question that the conditions prevailing were in any way unsatisfactory. Seven of these cases were referred to the Children's Officer for further investigation.

The agency arrangements noted in last year's report for the reception of unmarried mothers for their care at the actual confinement, for their rehabilitation thereafter, and for the care of their babies at St. Monica's Home and Brettargh Holt Home, both at Kendal, have been continued.

Units for the reception of premature infants (that is children who weigh less than 5½ lbs. at birth) are in operation at the City Maternity Hospital, Carlisle, and the Workington Infirmary in West Cumberland. The appropriate figures, compiled locally, required by the Ministry of Health Circular L.N.A.L. 1/49, are as follows:—

Premature infants born at home		79
Died in the first 24 hours	10	
Died between 2nd and 8th day	3	
Transferred to hospital	10	
Survived 28 days	56	
Premature infants born in hospitals or nursing homes		107
Died within 28 days	29	
Survived 28 days	78	

Adding our own domiciliary figures and those from the hospitals together we arrive at the position that 186 babies were born prematurely, and of these 42 died before the 28th day. The Registrar General has only classified 28 of these as due to prematurity. One cannot help feeling that even if some other cause is ascribed as the principal cause of death, in the majority of cases prematurity must have been a contributory cause, and beyond doubt this matter of the deaths of premature infants within 28 days of birth calls for close attention.

Turning now to ante-natal examinations, the figures are as follows:—

Examinations at practitioners' surgeries ...		977
Examinations at patients' homes		452
Examinations by practitioners at clinics ...		112
Re-examinations		1,223
Total ...		2,764
Findings at examinations ... Normal ...		1,126
Abnormal ...		415
Recommended for hospital on account of home conditions		303
Recommended for hospital on account of patients' condition		67
Recommended to be examined by specialist		62
Post-natal examinations		542

The reference to clinics in the above table refers merely to one or two districts in which one or more practitioners utilise the facilities of our County Council clinics for the examination of ante-natal cases in co-operation with the midwives. In addition to the above figures there has, of course, been a vast amount of work undertaken at the hospital ante-natal clinics carried out by the specialists attached to the hospitals working under the auspices of the hospital management committees. We have, as an authority, referred substantial numbers of cases for ante-natal examination and advice to specialists at these hospital clinics.

The number of women from the administrative county confined in hospital during the year was 1,866, almost equally divided between East and West Cumberland. In addition an unknown number were confined in private nursing homes, some of which are in the administrative county and some in Carlisle. During the year 220 women received ante-natal care in hospital as in-patients.

With regard to post-natal examinations, 542 reports were received from practitioners during the year. This shows a very substantial increase on the figures for the last six months of 1948.

With regard to children's nurseries, the situation remains unchanged at the moment. Our day nursery provision is still limited to the day nursery at Whitehaven, and our residential nursery provision is primarily at Sandath, Penrith, where there is accommodation for some 40 children, with an overflow as occasion requires, to the children's homes at Englethwate, Scotby and Orton Park. Two new residential children's homes are in prospect, but neither is likely to be in operation during 1950. One of these at Greenhill, Wigton, is likely to open early in 1951. The other at Geltsdale, Wetheral, may not open so soon. Both of these homes will accommodate a certain number of children under five in addition to older children.

SECTION 23.

Midwives Service

During the year 132 midwives notified their intention to practise. These notifications included 80 midwives employed by nursing associations, 12 employed as municipal midwives by the County Council, 6

independent midwives and 34 midwives working in the maternity departments of hospitals. The number of midwives actually undertaking domiciliary midwifery at the end of the year was 74.

Reference has been made earlier to the problem of recruitment. It has been pointed out that while we have been able to maintain district nurse midwives in most districts continuously throughout the year, there have been periods when there have been vacancies, and at the time of writing there are two vacant districts. It has been quite impossible to attempt to build up a staff of relief midwives, with the result that not all of the district nurse midwives have been able to have the off-duty time prescribed by the Rushcliffe Committee, although the position is improving.

The Superintendent Nursing Officer or her assistants made 128 routine visits of inspection during the year. In addtion 209 other visits were paid in connection with puerperal pyrexia and other special matters. Visits to hospitals with maternity units amounted to 18, and the midwives inspected at these visits numbered 44.

During the year midwives attended 1,245 domiciliary cases as midwives and 572 cases as maternity nurses. The total of these two figures shows a decrease of 254 domiciliary cases compared with 1948. The reason is the increased number of patients admitted to hospital for confinement.

The following short table shows the position in respect of ante-natal visits by midwives, covering both midwifery and maternity.

Home visits	13,978
Attendances at nurses' clinics ...	5,640
	19,618

During the year midwives sent for medical help for domiciliary cases on 593 occasions.

Gas and Air Analgesia.

During the year a further 15 midwives were trained in gas and air analgesia, making a total at the end of the year of 65 midwives certificated in this respect. At the moment 9 midwives have not received this training. It is intended to train 4 of these when vacancies are obtainable. The remaining 5 will not be trained.

The number of occasions on which gas and air analgesia was employed in domiciliary midwifery or maternity cases by midwives during the year was 878, of which 648 were in midwives' cases. This means that in approximately one half of the domiciliary confinements gas and air analgesia is employed. The reasons given last year in explanation of the much smaller proportion—at that time less than one-third—were as follows:—

(a) A considerable number of women apparently still do not desire analgesia.

(b) Midwife summoned too late.

(c) The practitioner administers his own anæsthetic.

These reasons still operate, but to a lesser extent.

Recently the Central Midwives Board have issued an authorisation in respect of the use of pethedine by practising midwives. This is a preparation usually administered by intra-muscular injection, the action of the normal dose being more or less equivalent in analgesic action to a small injection of morphia. It is a drug in which administration by a midwife cannot be sanctioned unless the midwife submits proof of experience in administration, and at the moment I have only authorised one midwife in the county to use this drug.

Turning now to other matters., maternal deaths during the year amounted to 7, as follows:—

Puerperal sepsis	1
Other puerperal causes	6

This gives a maternal mortality rate of 1.74, and for comparison the figures for the immediately preceding years are shown below:—

1944—	6	deaths	equal	to	a	rate	of	1.5	per	1,000 births
1945—10	,,	,,	,,	,,	,,	,,	2.9	,,	,,	,,
1946— 6	,,	,,	,,	,,	,,	,,	1.4	,,	,,	,,
1947— 2	,,	,,	,,	,,	,,	,,	0.44	,,	,,	,,
1948— 6	,,	,,	,,	,,	,,	,,	1.43	,,	,,	,,
1949— 7	,,	,,	,,	,,	,,	,,	1.74	,,	,,	,,

The distribution of deaths by areas is shown in the table below:—

	Puerperal sepsis.	Other puerperal causes.
Workington Borough ...	—	... 1
Whitehaven Borough ...	—	... 1
Ennerdale R.D. ...	—	... 2
Wigton R.D.	1	... 1
Millom R.D.	—	... 1

Apart from those county cases admitted to local hospitals for confinement during the year, 19 cases were

admitted to St. Monica's Home, Kendal, and one case to Brettargh Holt Maternity Home, Kendal. The maternity unit at Meadow View House, Whitehaven, accounted for 17 confinements.

Twenty-one cases of puerperal pyrexia were notified during the year, of which 5 were admitted to the isolation block at the Cumberland Infirmary.

Abortion.

The following table shows the distribution by areas of cases in which medical help was sent for by midwives on account of abortion. The number of cases involved is considerably lower than for 1948, for which year the total figure was 53.

	1948.	1949.
Workington Borough ...	17	6
Whitehaven Borough ...	1	1
Cockermouth Urban ...	4	1
Maryport Urban ...	1	3
Penrith Urban ...	2	—
Border Rural ...	3	2
Cockermouth Rural ...	5	10
Ennerdale Rural ...	8	5
Millom Rural ...	5	—
Penrith Rural ...	2	2
Wigton Rural ...	5	9
	53	39

SECTION 24.

Health Visiting.

Our staff of whole-time health visitors amounts on paper to 17, but there are three vacancies which we are unable to fill. The prospect of reaching our target of 30 whole-time health visitors, provided for in our "proposals," seems to be receding into the background. These figures are exclusive of the substantial number of district nurses who act as part-time health visitors, some 48 district nurses being so employed under a temporary year-to-year dispensation by the Ministry. The National Health Service Act and Circular 118 envisaged a substantial expansion in the numbers and functions of health visitors, but, as I said twelve months ago, these questions at the moment are merely academic, because the health visitors are simply not obtainable.

The amount of work undertaken by the health visitors as such during the year, including district nurses, was as under:—

Visits to children under one year	... 34,096
Visits to children aged 1-5 years	... 32,239
	66,335

Reference was made last year to what I described as the increasing liaison being established between the hospitals and this department in repect of the after-care of patients discharged from hospitals. I am sorry to say that at the moment this liaison seems to be decreasing rather than increasing. In the West of the county especially this liaison is not at the moment by any means what it ought to be, but I hope that, arising out of circular H.M.C. (50) 21, to which reference is made elsewhere in this report, a more satifactory position will develop.

The health visiting service naturally brings us into close association with the children's department, and I think it is fair to say that every case calling for the attention of the Children's Officer is brought to her notice.

SECTION 25.

Home Nursing.

No substantial change took place during the year, but reference has been made elsewhere to the termination of the agency arrangement with the County Nursing Association, so that at the time of writing we are now directly operating the home nursing service. The problems arising have been discussed in other parts of this report. Our target is to appoint to every nursing district in the county a state registered nurse, and. as far as may be possible, a state registered nurse holding the Queen's qualification. At the moment we employ as district nurses 17 Queen's nurses and 22 state registered nurses out of a total of 75 posts involved. The balance are state-enrolled assistant nurses with the midwives qualification.

The statistics relative to home nursing in respect of 1949 are as follows:—

Number of cases nursed	... ...	7,778
Number of nursing visits paid	... 98,179	
Number of casual visits paid	... 12,735	—110,914

SECTION 26

Immunisation and Vaccination

The number of children under school age immunised during the year was 3,193, practically the same as for the year before. The number of school children receiving either primary or reinforcing injections, was 7,216, making a total of 10,409 immunisations which represents a substantial increase over the previous year. Of this total 724 reports in respect of immunisations were received from general practitioners. These were almost exclusively children under school age and are included in the above figures. The immunisation figures may in fact be even larger than those given because no doubt a number of immunisations will have been undertaken by practitioners who have not sent in reports and who have not claimed the appropriate fee for such reports.

The percentages of immunised children in the county have been worked out and are as follows:—

Under 5 years	...	...	...	54.0%
5 to 15 years	...	...	...	89.9%

The story with regard to vaccination which, of course, ceased to be compulsory as from 5th July, 1948, is not so good. Here we depend entirely upon reports of successful vaccination received from practitioners.

During the year 973 reports of successful primary vaccination were received and 65 reports in respect of re-vaccination.

This represents a sharp fall in vaccination since it ceased to be compulsory. There is no doubt, of course, that in this county the population is becoming less and less protected against smallpox, and it will not be until cases of smallpox occur in the area, or in an adjoining area, or perhaps not until there are one or two fatal cases that the queues will begin to form.

I am not quite clear that the above figures give a complete picture because, for example, since the recent Glasgow epidemic there were fairly extensive vaccinations by groups in connection with certain undertakings in the county in respect of which we would

not normally receive reports, the vaccinations having been undertaken by Medical Officers attached to the organisations in question. All that we can say at the moment is that during 1949 about 1 child in 4 appears to have been vaccinated, so far as we know. The figure of infant vaccinations (i.e., under 12 months of age) in the English counties for 1949 was 15.9%, so that we seem to be at least up to the average.

SECTION 27

Ambulance and Sitting-Case Car Service

(a) Ambulance Service

This part of the transport service has continued to work smoothly and efficiently during the year. One or two changes in the administrative set-up have occurred, whereby the agency arrangements explained in last year's reports have been replaced by direct contracts with private firms. In Workington the county ambulance is now garaged at the Fire Station and serviced by the Fire Service personnel, but drivers are provided by a private firm. In Whitehaven district a private firm has taken over under contract the provision of ambulances and their maintenance and servicing.

As will be seen from the table which follows, the ambulance service has continued to run at a very economical figure.

Ambulance Service (apart from Sitting Case Cars)

Statement showing the cost of the service to the County Council (excluding the capital cost of the Ambulances) for the year ended 31st March, 1950, and comparison for the nine months (5/7/48 to 31/3/49)—5th July, 1948, being the date of inception of the service.

	Year ended 31st March, 1950.			5th July, 1948, to 31st March, 1949.		
	Mileage.	Running expenditure.	Running expenses in d. per mile.	Mileage.	Running expenditure.	Running expenses in d. per mile.
		£	d.		£	d.
By whom ambulance managed:						
Voluntary Committees or County District Councils (8 ambulances) ...	72,938	3,522	11.59	62,727	2,923	11.18
Hospital Management Committees (4 Infectious Diseases Ambulances) ...	15,715	430	6.56	9,434	317	8.06
County Council — through garage proprietors (2 ambulances) ...	18,015	1,386	1/6.47	6,429	532	1/7.86
Carlisle Corporation ...	1,229	117	1/10.85	816	51	1/3.00
do. N.H.S. (Amendment) Act, 1949 ...	3,651	411	2/3.00	—	—	—
Other Local Authorities Amb. charges ...	210	22	2/1.14	—	—	—
2 Proprietors using their own ambulances, viz., Collins, Alston, and Brownrigg, St. Bees ...	17,417	762	10.50	6,345	265	10.02
	129,175	£6,650	1/0.36d.	85,751	£4,088	11.44d.

The total number of ambulance journeys during the year was 3,885 (4,035 patients) of which 857 were in respect of accidents or emergencies.

During 1949 three new County Council ambulances of different types were delivered, and orders have now been placed which will make the position such that by early in 1952, every general ambulance in the county will have been replaced by a new vehicle, and the infectious disease ambulances will have been replaced either by new vehicles, or by the best of the present general ambulances. We will also have available and in reserve one or two quite efficient ambulances made available by replacement. This position is satisfactory.

We are building up a system of ambulance attendants (Red Cross and St. John Ambulance Brigade personnel, retired nurses or other suitable persons), who will be paid as and when employed at the rate of 2s. 6d. per hour with a maximum of 20s. in any given 24 hours, together with appropriate subsistence. I am sure that this is the only economic way of providing ambulance attendants in a scattered rural county like Cumberland. To establish a rota of whole-time male and female ambulance attendants attached to each of our ambulances, scattered as these are all over the county, would be a gross waste of public money. For a large part of their time persons on such a rota would be twiddling their fingers waiting for something to turn up.

On the matter of ambulance equipment, we have now received a directive from the Ministry as to what should be provided. In point of fact we have already made provision for an almost exactly similar list of equipment to be carried in all our ambulances, and it may be worth recording that we are giving an extended trial to the use of one-man stretchers.

(b) Sitting-Case Car Service

This branch of the transport service has continued to be the cause of a good many headaches. Experience has shown that this service is exceedingly costly, is open to abuse, and has in fact been abused, and that the available work has not been equitably distributed among the co-operating taxi proprietors. Our approach

in this county to this service has been off what I imagine is the general pattern. I think most counties have dealt with the matter either by providing their own sitting-case car service, or by depending largely—in some cases almost exclusively—on the hospital car service, or by providing special vehicles of the shooting brake type, capable of carrying a number of sitting cases.

None of these lines of approach meets the case in Cumberland. The hospital car service only provides adequately for certain parts of the county, although it is hoped, as mentioned later, to expand our use of this service, and to maintain our own fleet of sitting-case cars or special vehicles operating from two or three central ambulance stations would be uneconomic and extravagant in mileage. Our approach has therefore been to obtain by advertisement the names of private garages or private taxi proprietors who are prepared to co-operate in this service, and, as a result, a list of rather more than 100 such firms or individuals has been approved by the Council for this purpose. The scales of payment under which the service operates are as follows:—

(a) 9d. per mile, plus 2s. 6d. for the first completed hour of waiting time and 1s. 3d. for each completed half hour of waiting time thereafter.

(b) A minimum charge of 3s. for short journeys, except between the hours of 12 midnight and 8 a.m., when the minimum charge is 4s. 6d.

Prolonged negotiations were necessary before these rates came into operation for the whole county. Reference is made above to the fact that experience has shown that the sitting-case car service organised on the above lines was open to some criticism on account of abuse, unequal distribution of the work, and in one or two other matters. There is no doubt that not only have quite a few people utilised the service who did not require it, but there is equally no doubt that many people continued to use the service long after they were able to travel by public transport. In respect of this latter point, the hospitals, and particularly the rehabilitation departments of the hospitals, have not been free from responsibility. It has been found, too, that when a sitting-case car, or in some cases an ambulance, has been provided at the

request of a medical practitioner or hospital, the original authority has been used as justification for many repeat journeys, often quite unnecessarily or at least for far too long.

After due consideration of all these matters, the Council have decided to establish at the Cumberland Infirmary for East Cumberland, and at the health department's divisional office at 102, Scotch Street, Whitehaven, for West Cumberland, calling-out bureaux under the charge of liaison officers whose duty it will be (a) to prevent abuse of the service (b) to co-ordinate incoming and outgoing transport to the best advantage (c) to spread the work equitably among the contracting taxi proprietors, and (d) to co-ordinate the requests of the medical practitioners, hospitals and others under a properly balanced and integrated organisation, and (e) to expand the use of the hospital car service.

The setting up of these bureaux, however, from which we hope much, will not completely solve the problems at issue, and therefore appropriate directions are being prepared for the information of all concerned, together with slightly amended regulations for the calling out of vehicles, which are reprinted below. If these regulations are by - passed the Council will repudiate any financial liability.

"REGULATIONS FOR CALLING OUT OF VEHICLES"

1. EMERGENCY JOURNEYS—AMBULANCE OR SITTING-CASE CAR.

Who may summon vehicle.	*How to summon vehicle.*
Any person.	By telephone (or messenger) to the nearest ambulance or sitting-case car operator—see list.

Medical aid should be summoned at the same time, and if appropriate the police should be informed.

"Emergency" includes incidents such as road or other accidents, hæmorrhage, collapse from any cause, severe burns, poisoning, women in labour.

2. Journeys other than Emergencies—Ambulance or Sitting-Case Car.

Where the patient is unable on medical grounds to travel by public transport:—

Who may request vehicle.	*How to request vehicle.*
(a) Medical practitioners.	Where hospital appointments system in operation, hospital will arrange. Otherwise, send Form Amb/7 to call-out bureau — see below.
(b) Hospitals, including nursing homes, district nurses and midwives, approved officers of the County Council, police and fire service officers. Such other persons as may be authorised by the County Council.	Telephone or write to call-out bureau — see below. *Note*: When the call-out bureau is closed the nearest ambulance or sitting-case car may be summoned by direct call.

Call-out bureaux:—

East Cumberland—Cumberland Infirmary.
Telephone: Carlisle 590.

Hours (except public holidays):—
Monday/Friday ... 9-0 a.m. — 5-15 p.m.
Saturday ... ... 9-0 a.m. — 12-15 p.m.

West Cumberland — Divisional Health Office, 102, Scotch Street, Whitehaven.
Telephone: Whitehaven 792.

Hours (except public holidays):
Monday/Friday ... 9-0 a.m. — 5-15 p.m.
Saturday ... ... 9-0 a.m. — 12-15 p.m.

3. Infectious Diseases.

Ambulances for infectious diseases will continue to be called out as at present.

4. Out-County Journeys.

Journeys to destinations outside Cumberland (except (a) emergencies, and (b) journeys to the North Lonsdale Hospital, Barrow) will be arranged by the County Health Department, 11, Portland Square, Carlisle. Telephone: Carlisle 950.

5. "*The County Council will not accept financial responsibility for transport provided otherwise than in accordance with these regulations, nor will the Council accept responsibility for arrangements made privately save in the most exceptional circumstances.*"

The calling out of vehicles, except where the patient is attending under an appointments system, and except in emergency, will be done by means of a simple form to be forwarded by the practitioner, hospital or other approved source, to the appropriate bureau in a franked addressed envelope.

The following short table shows the general position:—

Sitting Case Car Service, 1949

Journeys authorised by:—					
Doctors ... ... 9,094)					
Hospitals ... ... 5,473)	No. of	No. of	Mileage.	Cost per	
County Health Department 280)	journeys.	patients.	run.	mile.	
Duly Authorised Officers ... 129)	15,430	16,834	401,064	11.04d.	
Others ... ... 454)					

(c) Hospital Car Service

This service continues to be operated for the Council on an agency basis by the British Red Cross Society, and continues to prove invaluable. There are some seventy car owners co-operating in this service. The distribution of these over the county is naturally not regular, and there are one or two areas in which there are few, if any, car owners operating. On the other hand in some areas there are more drivers than the work hitherto allotted to the hospital car service requires. As will be seen from the following table the sources at present using this service are confined to the offices of the health department and to certain

hospitals. It is hoped that the establishment of the bureaux will remedy this position. It is quite obvious that there is no object in the County Director recruiting additional drivers if insufficient calls are made on the service to justify this. The following table shows the general position:—

Hospital Car Service, 1949

Journeys authorised by:—

Doctors ... ... Nil.)					
Hospitals ... ... 1,096)	No. of journeys.	No. of patients.	Mileage. run.	Cost per mile.	
County Health Department 450)					
Duly Authorised Officers ... Nil.)	1,546	1,857	62,860	6.25d.	
Others ... ... Nil.)					

The only comment called for is that the work has substantially increased during the year. For the six months July to December, 1948, the mileage run was just over 21,000, and as will be seen, the figure for 1949 is three times that amount.

SECTION 28

Prevention of Illness, Care and Aftercare

I have never been clear precisely what is intended by this section. I hope sometime I may meet someone who will be able to explain it to me, but so far no such person has appeared. We do undertake, I suppose, a considerable amount of what could be classified as aftercare in directions indicated in other sections of this report, such as the provision of convalescent treatment, the aftercare of orthopædic cases by plaster work, provision of appliances, and so on.

In the matter of prevention of illness we co-operate with the consultant in venereal diseases for the tracing of contacts, and for the bringing of cases to the clinics in which a Wasserman test is indicated, arising out of reports from the ophthalmologists or from other sources. We do a certain amount of Rh. testing in expectant mothers in cases not attending hospital clinics. I am not at all satisfied with the position in this respect, but it will be appreciated that in a scattered rural county the institution of such a service is extraordinarily difficult, depending as it does on the co-operation of so many persons.

We have issued, as noted elsewhere, minor equipment, and are taking steps to establish depots for the issue of what might be called heavy equipment (bath-chairs, water and air beds, crutches, etc.) to district nurses for use by their patients. I think during the current year we will probably have established four or five depots in different parts of the county to cover this service.

In the matter of B.C.G. vaccination, which I suppose could be classed as prevention *par excellence*, we have amended our proposals on the lines suggested by the Ministry, and this service will begin, under the direction of the Chest Physician, in June, 1950. We have not yet tackled the extremely difficult question of providing segregation for child contacts of infective patients in cases where relatives or friends are unable to provide accommodation. As mentioned elsewhere in the report, the extension of our residential nurseries and children's homes, which is in progress, should go some way to solve this problem. B.C.G. vaccination appears to be a matter on the value of which opinions differ, and it is, of course, quite clear that a generation will have to pass before the results can be assessed, but in the meantime plans are slowly maturing for the development of this work.

One great difficulty in the development of work under this section is the continued difficulty in recruiting health visitors. Reference is made to this matter elsewhere in the report, but as health visitors hold key positions, the present scarcity must of necessity hold up progress.

I think the time may not be far distant when the Council may require to increase its staff of social workers, who have in the past largely been, and are to some extent at present, provided through voluntary agencies.

SECTION 29

Home Help Service

This service has proceeded smoothly throughout the year on a slowly expanding basis. Reference was made in last year's report to the change in the organisation of this service, whereby, after the resignation of

the organiser and after our failure to obtain any suitable applications for this post when advertised, the Council determined to place the organisation of the service, apart from assessment and the financial aspect generally, in the hands of the Superintendent Nursing Officer, subject to my general supervision. This arrangement has worked smoothly and well. The advantage is that through her staff of assistant nursing officers, and through the district nursing organisation which covers the whole county, contact with persons desiring to enrol as home helps, and contact with persons desiring the services of home helps, is greatly simplified, and travelling and telephone calls are correspondingly reduced.

The Superintendent Nursing Officer and her assistants took over these new duties on the 15th June, 1949, and from then until the end of the year Miss Mansbridge and her assistants paid 760 visits to householders and home helps.

I would again like to emphasise the fact that the nursing services are not concerned with the financial side. The assessments are undertaken by the County Welfare Officer and his district welfare officers, and contributions are collected by the County Treasurer. The nursing personnel are concerned solely with the finding of suitable persons to be enrolled in the service, and with fitting these persons into households in which the need for home help arises.

As will be seen from the attached statistics, there has been some expansion of the service, the figures for the previous year being given for comparison where appropriate. The picture changes from week to week, and indeed almost from day to day. For example, at the time of writing this report Penrith, instead of having two enrolled home helps, has none, and Millom instead of having one, has four. It cannot be said that the service is evenly distributed over the county. There are areas in which we have too many enrolled home helps, and there are areas in which we have too few or none at all. The provision of home helps when these are applied for from the more rural areas of the county is often difficult because of distances and lack of adequate transport. It is for this reason that

inaccessibility is given later as a reason for non-supply of home helps. Miss Mansbridge tells me that that is, in fact, the chief reason for non-supply, and I see no way of overcoming this difficulty. The difficulty could, of course, to some extent be overcome if we had a rota of home helps prepared to be *mobile* and *resident,* but such people do not seem to exist, and even if they did, in many country cottages there is no accommodation for a resident home help.

As I said last year, unfortunately in quite a number of cases where the services of a home help are badly needed, the householders are unable to meet the assessment involved, although the Health Committee are prepared to consider each case on its merits, and have, in fact, varied the assessment in a number of cases in which special circumstances were disclosed.

One or two other points are worth referring to. Some areas appear to have had a good deal of trouble with relatives desiring to act as home helps. Obviously this is a matter which could be open to a good deal of abuse, but fortunately so far it has not been one of our headaches in this county.

Another point of importance is the provision of home helps in infectious cases, and taken by and large that means pulmonary tuberculosis. Clearly no better instance of a household in which real need for help exists could be imagined than one in which the wife and mother is a tuberculous patient, but that is an infectious disease with which people are understandably hesitant to be brought in contact if they can avoid it. It has been suggested that some additional payment per hour in the shape of "danger" money might be paid to persons acting as home helps in tuberculous households, but the very words "danger money," and in fact the very payment of additional money is liable to cause people to see the red light. A colleague in another county* has suggested that the position might be met by selected home helps attending special courses of training in connection with infectious diseases, and in particular in connection with tuberculosis. Certainly all home helps in attendance on tuberculous households should be under regular supervision by the Chest Physician Service, and this has been arranged.

*Middlesex.

Subject to these general observations, the statistics for the year are as under:—

1st January, 1949, to 31st December, 1949

Home Helps:		**1949**	**1948**
No. of persons who have been accepted and enrolled on the Register:—			
Whole-time		49	63
Part-time		57	21
		106	84
Less persons resigned from Service		26	34
No. on Register at 31st December, 1949		80	50
Districts in which the Home Helps reside:—			
Alston		—	1
Border Rural		9	6
Cockermouth		9	3
Ennerdale Rural		8	6
Keswick		1	2
Maryport and Dearham		14	7
Millom and District		3	—
Penrith		2	4
Silloth		5	5
Threlkeld		2	1
Whitehaven		8	4
Workington		13	7
Wigton		6	4
Total		80	50
Householders:—			
No. of application received for Home Helps:		290	162
No. provided with Home Helps:			
Confinements	65		
T.B. Cases	5		
Other	123		
		193	105
No. cancelled or not supplied		97	57
		290	162

The reasons for non-supply have been more or less varied as before:—

(a) Householder has made other arrangements after application.

(b) The householder considered the cost too high.

(c) No home help available.

(d) Death of patient, or removal to hospital.

(e) Inaccessibility.

SECTION 51

Mental Health Service

The Ministry, in Circular 2/50, have asked that information in respect of the Mental Health Service shall be submitted under the same general headings as were introduced last year. The following notes, broadly speaking, therefore follow these headings.

1. **Administration**

This matter was dealt with in detail last year, and the general set-up was very fully explained. No useful service would be performed by a repetition, but certain important changes took place. Of these the most important was the termination of the arrangements with the Voluntary Mental Welfare Association. This agency arrangement terminated on the 30th November, 1949, after which date the Council took over the direct administration of the service. Perhaps the principal factor in bringing the agency arrangement to an end was the serious illness of Miss Moclair, to whose services reference was made in last year's report, and who had acted as liaison officer between the Authority and the Voluntary Association. Unhappily our hopes that relief from the strain of her work would be followed by an improvement in her health were not realised, and her death took place early this year.

We took over certain staff from the Voluntary Association, including Miss Taylor, B.A. (Social Science) recently appointed to fill a vacancy as mental health worker. Mrs. Campbell, who had for a number of years been our part-time psychiatric social worker in West Cumberland, has resigned as from the 31st January, 1950, and all efforts to secure applications for this vacant post have so far failed. Reference to the seriousness of the position in filling vacant posts is made elsewhere in this report. Miss Burrows, M.A., joined the staff as educational psychologist in May, 1949.

The Ministry ask that the staff employed in the Mental Health Service should be set out in some detail, and as this was not done last year, the information is given below. It will be noted that

the part-time services of certain of the personnel have been seconded to us by the Special Area Committee.

Certifying Officer (*Mental Deficiency Act*, 1913): Dr. Kenneth Fraser.

Approved Medical Officers: Dr. Fraser, Dr. Hunter, Dr. Jones, Dr. McMurtrie, Dr. Gavin, Dr. Thomson, Dr. Knox, †Dr. Braithwaite, and †Dr. Ferguson.

Psychiatrists: Dr. Braithwaite and Dr. Ferguson (seconded from the Regional Hospital Board).

Administrative Assistant (*Mental Health*): Miss Greenwood.

Educational Psychologist: Miss Burrows, M.A.

Psychiatric Social Workers:

(a) West Cumberland. Vacant. Mrs. Campbell resigned January, 1950.

(b) East Cumberland. Miss Mildred Lamb, seconded from the Special Area Committee in connection with the East Cumberland Child Guidance Clinic.

Mental Health Workers: Miss E. F. Hall and Miss M. G. Taylor, B.A.

Occupation Centres Supervisor and Home Teacher: Vacant.*

Do. Assistant Supervisor and Home Teacher: Mrs. Lax.

Handicrafts Teacher: Miss Cooper.

Duly Authorised Officers (*Part-time*): Mr. J. J. Brown, Mr. W. H. Coulthard, Mr. T. J. Archer, Mr. J. Housby, Mr. W. J. Wilson, Mr. J. Calvert, Mr. G. A. Carruthers, Miss E. A. Fox, Mr. H. Sewell.

Deputy Duly Authorised Officrs: Mr. D. W. Jack, Mr. J. H. Hocking, Mr. J. D. Messenger, Mr. J. Gibson.

† Approved for cases in connection with the Child Guidance Clinics.

* Since filled by the promotion of Mrs. Lax.

2. **Work undertaken in the community.**

(a) Under Section 28, National Health Service Act, 1946.

Child Guidance Clinics are held in Whitehaven and Carlisle, and a third small clinic is held in Workington in not very suitable premises. Arrangements are in hand to obtain better premises at Maryport, which will allow of increased attendances. Child guidance is, of course, primarily an educational problem, and the statistics have been given in the Annual Report on the School Health Service, but as it is part of the general set-up in mental health a short reference here seems appropriate.

(b) Under the Lunacy and Mental Treatment Acts, 1890-1930.

Cumberland cases dealt with under the Lunacy and Mental Treatment Acts, 1890-1930 during the year amounted to 197, of whom 141 were voluntary, 53 certified, and 3 temporary. Of the total, 87 were men and 110 women. The arrangements for the admission of these patients to the Mental Hospital are undertaken by the Duly Authorised Officers.

(c) Under Mental Deficiency Acts, 1913-1938.

(i) *Ascertainment.*—During the year 1949, 301 cases were referred to the department for investigation. Of these, 44 were ascertained as mentally defective, and as 32 of the 44 were children of school age, they were reported by the Local Education Authority to the Health Authority for the purposes of the Mental Deficiency Act, 1913. Of the remainder, 29 children of school age were recommended for special education either at residential schools or special classes, and 74 were referred to the child guidance clinics. At the end of the year there were 41 patients awaiting hospital accommodation, most being urgent, and some cases of extreme urgency. During the year no more than 17 petitions were presented owing to the difficulty of obtaining institutional accommodation. It is recognised that the above

figures are very low and in almost every case much lower than they should be, but until facilities of an institutional nature for mental defectives become more readily available, and until special residential schools and classes for educationally sub-normal children approximate more nearly to the need, there is no useful purpose to be served in pushing ascertainment and certification.

(ii) *Guardianship and Supervision.* — At the end of the year there were 66 patients under guardianship, which is rather fewer than for 1948. The financial responsibility for these patients, except those under the age of 16, has been transferred to the National Assistance Board as from April, 1949. At the end of the year there were 119 patients under statutory supervision, compared with 99 for the previous year, and 52 under voluntary supervision compared with 23 for the previous year. It is hoped that in due course a considerable proportion of child patients under statutory supervision will be able to attend occupation centres.

(iii) *Training.*—Early in the year a small occupation centre, which will eventually cater for up to 15 children, was opened in Whitehaven. This centre will draw children from an approximate radius of five or six miles. It is hoped shortly to establish another occupation centre at Maryport, and in the meantime a small off-the-pattern centre for a few children is being held at Silloth in the home of one of the pupils. A small handicrafts class is held in Workington twice a week for adult patients. One of our difficulties in the development of the occupation centre service has been our failure to date to obtain any suitable applications for the post of supervisor. This post will shortly be re-advertised. Meantime we have been fortunate in obtaining the services of Mrs. Lax as assistant supervisor and home teacher. As I said last year, I hope that this service of providing occupation centres will expand substantially in the near future. Let me repeat what these occupation centres do,

because not everyone understands. They provide some elementary training for the children and some hours relief two or three times a week for mothers who have the misfortune to have to look after a rather low grade mentally defective child. They are therefore analagous in many ways to the services provided by day nurseries or crèches, and they are perhaps even more valuable in that they do relieve the tension in the homes concerned, and this tension, as those of us know who have some knowledge of mental deficiency, can be an intolerable and devastating burden.

3. Institutional Treatment.

On the 31st December, 1949, the County Council was responsible for 537 mental defectives. Of these, 300 were in institutions or on licence therefrom as follows:—

	1949	1948
Dovenby Hall Hospital	202	202
Milnthorpe Institution	48	45
Durran Hill House, Carlisle	7	8
Totterdown Hall, Weston-Super-Mare	1	2
The House of Help, Bath	1	1
Rampton State Institution, Notts. ...	7	5
Moss Side State Institution, Maghull, Liverpool	3	1
The Royal Albert Hospital, Lancaster	11	8
Hortham Colony, Almondsbury, Bristol	1	1
St. Mary's Home, Alton, Hants. ...	4	4
Lemmington Hall, Alnwick ...	3	1
Howbeck House, West Hartlepool ...	1	1
Bishop Auckland Institution, Durham	1	2
Lisieux Hall, Whittle-le-Woods, Chorley	5	5
Calderstones Institution, Whalley ...	1	—
Aycliffe Hall, Heighington, Darlington	2	—
St. Raphael's, Barvin Park, Herts ...	1	—
Prudhoe and Monkton Hospital, Prudhoe	1	—
	300	286

REPORTS AND NOTES ON INDIVIDUAL SERVICES AND OTHER MATTERS.

Tuberculosis.

Dental Service.

Orthopædics.

Venereal Disease.

Cancer.

Infectious Diseases.

Food and Milk.

Housing.

Water and Sewerage.

Agency Arrangements.

Laboratory Services.

TUBERCULOSIS.

Many points of interest arising under this heading seem worthy of comment. The outstanding points are really two. First that the *notifications of pulmonary tuberculosis at* 222 *were much the highest for* 16 *years, and, second, that sanatorium admissions at* 101 *were much the lowest for the same period,* and probably for longer. I have not investigated the earlier years. This most unfortunate discrepancy is partly due to the fact that much reconstruction and adaptation was going on at Blencathra Sanatorium during the year, and is partly due to the lamentably small number of sanatorium beds available for children.

During the three years 1936 to 1938 inclusive, which were our peak years for sanatorium treatment, we admitted to Blencathra and Meathop sanatoria an average of 182 cases per year. During the three years 1947 to 1949, inclusive, which were at the opposite extreme, we admitted an average of only 118 cases per year.

As regards children, from 1936 to 1938 inclusive, we admitted an average of 89 children per year either to Stannington Sanatorium, or to Eastby Sanatorium, which was a combined sanatorium and open-air institution for pre-tubercular children, now closed. During the three years 1947 to 1949 inclusive we admitted an average of 6 children per year to Stannington Sanatorium, and *in the last two years we have only admitted* 5 *cases in all.*

The lamentable position regarding sanatorium bed accommodation needs no further demonstration. It should perhaps be added that, in addition to the above sanatorium admissions, a small number of persons, averaging about 13 a year, have been admitted, generally on account of home conditions, and for the protection of contacts, to the pavilion at the City General Hospital, Carlisle, and to the isolation block at the Cumberland Infirmary, but the beds at these institutions cannot properly be classed as sanatorium beds.

Towards the end of the year the Special Area Committee, in conjunction with the County Council and the Carlisle City Council, appointed a Chest Physician, to be in charge of the pulmonary tuberculosis service, including the dispensary service, but excluding the administrative control of Blencathra Sanatorium, which remains in the hands of the Medical Superintendent.

Dr. W. Hugh Morton, the successful applicant, took up his duties on the 1st February, 1950, and at the

moment of writing has his headquarters in the offices of the County Health Department. Later in the year, when the Chest Clinic at the City General Hospital is open that will be the headquarters of the Chest Physician Service, which, of course, includes other conditions than pulmonary tuberculosis. The Chest Physician's remuneration and time are allocated between the Special Area Committee, on the one hand, and the local health authorities on the other, in the proportion of 8/11ths and 3/11ths, and there is no doubt that co-operation between this new service and the health departments of the two authorities will be closely maintained in the future.

As a matter of public interest, although it is not in any way our concern, it is worth mentioning that, later in 1950, a mass radiography unit, to which a brief reference was made in last year's report will be in operation in the area.

With reference to B.C.G. vaccination against tuberculosis, we have submitted to the Ministry, for approval, a variation of our proposals under Section 28, to cover this matter. The variation is on the standard lines suggested by the Ministry.

B.C.G. vaccination is a service which will be carried out under the direct supervision of the Chest Physician. It involves problems of various kinds, one of the most difficult of which is the arranging for the segregation of the vaccinated children from the infective patient for a period of approximately three months. It is too early to say much about this, beyond mentioning that our residential children's homes and nurseries seem to be the appropriate places for such segregation, in cases where relatives or friends are unable to offer the children accommodation, and assuming, of course, that accommodation will be available in these homes and nurseries as they expand and develop. A start has been made in this matter as this report is in preparation, and I understand that in the initial cases selected the infective persons are at present occupying sanatorium beds, so that the problem of segregation in these cases will not arise. This is a matter, however, as the service develops, which will have to be given considerable consideration.

A good deal has been written about the value of B.C.G. vaccination recently as a protective measure for

the contacts of tubercular persons. I think it is fair to say that the position at the moment is that, while great hopes are entertained, there is yet no clear scientific proof of the actual results. It may well be that a generation may pass before such results are available.

Table A.—Notifications

Year.	Pulmonary.	Non-Pulmonary.
1944	178	61
1945	182	71
1946	197	48
1947	162	58
1948	185	45
1949	222	32

The total deaths from tuberculosis are shown in the following table:—

Table B.—Deaths.

Year.	Pulmonary.	Non-Pulmonary.
1944	95	23
1945	122	26
1946	97	28
1947	101	32
1948	116	15
1949	107	25

The death-rate on the Registrar-General's figures for the Administrative County in respect of pulmonary tuberculosis for 1949 is .5 per thousand of the population, and in respect of non-pulmonary tuberculosis .12 per thousand of the population. These figures compare with .55 per thousand and .07 per thousand respectively for 1948 and call for no comment.

Deaths from pulmonary tuberculosis were distributed among the sanitary districts as under:—

Urban Districts	Deaths.	Death rate.
Cockermouth	—	—
Keswick	3	.65
Maryport	6	.49
Penrith	4	.38
Whitehaven	15	.63
Workington	15	.52
Aggregate of Urban Districts	43	.51
Rural Districts.	**Deaths.**	**Death rate.**
Alston	1	.43
Border	12	.42
Cockermouth	12	.61
Ennerdale	20	.69
Millom	3	.24
Penrith	7	.60
Wigton	9	.39
Aggregate of Rural Districts	64	.50
Total for the Administrative County	107	.5

The only point which seems to call for comment in the above statistics is the substantial fall in the death-rate in the Ennerdale Rural District, which has fallen by nearly half.

At the end of the year the beds occupied by pulmonary cases from the Administrative County were as under:—

	Beds.
Blencathra Sanatorium	55
Meathop Sanatorium	20
Stannington Sanatorium	4

The adaptations at Blencathra have now proceeded to the point when it is reasonable to expect, in the not too distant future, that some additional sanatorium beds will be available; that is, of course, for the Special Area. Even so the bed situation as noted before is deplorable. The waiting list at the end of the year was 63 cases, involving a time lag for admission of up to nine months. This matter has now passed into the province of the Chest Physician, and I believe that, at the time of writing, the waiting list for the Special Area has passed the hundred mark, and is continuing to rise. The Special Area Committee are very fully alive to the situation, and are making strenuous efforts to improve the position very substantially by obtaining approval to develop Camerton as a tuberculosis hospital, which would provide an addition of something like 80 beds. Whether this scheme—for which plans are well advanced—will receive the approval of the Ministry is not yet known.

The Year's Work.

The total number of cases admitted to institutions for diagnosis or treatment was as follows:—

	Males.	Females.	Totals.
Adults in Meathop and Blencathra	53 ...	48 ...	101
Children in Stannington ...	3 ...	1 ...	4
Other Institutions	6 ...	21 ...	27

The admissions of pulmonary cases to *sanatoria* during 1949, and the preceding years are shown below:

1945	143
1946	180
1947	139
1948	128
1949	105

The main statistics for the year are as under:—

	1948	1949
New cases examined at dispensaries	166	189
Number of contacts examined	960	1140
Number of pulmonary cases on the dispensary registers at the end of the year	741	813
Consultations with practitioners	401	521
Visits to homes of patients by tuberculosis officers	419	500
Visits to homes of patients by tuberculosis nurses	2325	3978
Sputum examinations	577	748
X-ray examinations	845	1054
Attendances at dispensaries	3155	4106
Shelters in use	20	18
Cases receiving extra nourishment	20	15

These figures call for no comment, except that, by comparison with 1948 they do, in nearly every case, represent a substantial expansion of work.

The number of patients attending the refill clinics at Carlisle and Workington continues to increase quite substantially. Weekly clinics are now held at both centres. The attendances at Carlisle amounted to 594, and at Workington to 1,003.

We continue to receive requests for examinations and reports in a number of suspected cases from the National Service Medical Board, from the Ministry of Pensions in respect of ascertained cases, and from the Ministry of Labour in connection with the Register of Disabled Persons.

DENTAL TREATMENT.

Report by the Senior Dental Officer (A. C. S. Martin, L.D.S.).

"It is unfortunate that the long overdue attempt to introduce a comprehensive scheme of dental treatment for the "under-fives" should have been introduced at the present time when the staffing position of the local authority dental services is chaotic. As indicated in last year's report every endeavour was made during 1949 to give both the maternity and child welfare services the time and attention they deserve but, for various reasons, results have been, in the main, most disappointing.

First, with regard to expectant and nursing mothers, notices offering treatment were sent out to

1,572. but of these only 261 took the trouble to return the form. For these cases appointments were duly made, but in many cases were not kept. For the remainder, treatment was carried out, the results being given in the accompanying table.

There is no doubt that, however efficient a local health authority dental service for adults may be, it still bears a stigma of financial need, especially in a county like Cumberland where, in the past, a very large number of public assistance cases were treated, particularly during the years of depression. The result is that when a patient can obtain treatment from a private practitioner without charge there will always be a preference in that direction. This, of course, is surmise, but it is the most reasonable explanation of the comparative lack of interest in obtaining treatment under the facilities available at the clinics.

It is probable that as the National Health Service settles down, and the general dental practitioners are able to cope with the work more adequately, the numbers of nursing and expectant mothers attending the clinics will become still less. This, of course, is not a matter of great importance provided the patients can obtain necessary treatment, but it must be emphasised that in the endeavour to operate a scheme in an area such as the county of Cumberland, a great deal of work is of necessity involved, which may show very little in return, and when appointments are made and not kept, a considerable waste of dental officers' time is unavoidable. It is difficult to see how this can be avoided, and in the meantime the procedure will be continued as at present.

Secondly, arrangements for pre-school children have been carried out as detailed last year. Here again the response has been disappointing. Notices were sent out to 5,898, but of these only 2,112 were returned. Whether ignorance or apathy is responsible it is difficult to say, but it is evident that while certain parents are anxious for their children to have proper dental supervision from an early age, the majority take very little interest in the matter.

It has not been possible so far to inspect all cases concerned. While shortage of time has certainly been a hindrance, the chief obstacle has been distance, which makes it difficult for mothers to bring children in to the clinics. While many of them are quite willing to come in when the child is demonstrably in need of

treatment, it raises a problem if a busy woman has to spend the better part of a day bringing her child for inspection, merely to be assured that the mouth is in good condition. On this account, those cases which live in the more remote areas have not been sent for, but it may be possible, when the position of the service becomes more stable, to arrange for these inspections to be carried out in the schools at the same time as a school dental inspection or dental treatment session is being held, but under present conditions, as the period between school dental inspections is steadily increasing, it would be unreasonable to add anything further, and thereby add to the confusion.

At the present time there is little point in embarking on new schemes or developments, when it is not possible to maintain in an adequate way even the responsibilities of the school dental service.

Reference has been made to the apathy of many parents with regard to this aspect of treatment, but what can we expect from them when we take account of the apparent apathy of those in positions of responsibility in relation to the progressive disintegration of the local authority dental services. When it is realised that this process has been going on since the introduction of the National Health Service, and that so far nothing has been done on a national basis to save the situation, it raises the question as to what is really meant by 'priority' treatment. Were is not for the action of certain local authorities who have, on their own initiative, raised salaries, it is doubtful if there would be any local authority dental service left at all."

The following information is given in accordance with the instructions of the Minister of Health. Full facilities are available for the X-ray examination of any patient in the county, not only in the clinics, but when desirable in any place where a suitable electric supply is available. A portable unit has been in use in Cumberland since 1938, and has fully demonstrated its efficiency as well as its convenience and adaptability.

In relation to the supply of dentures, all necessary work is carried out in the county workshop at Carlisle, where provision is made for all types of prosthetic work.

The tables given herewith indicate the patients actually inspected and treated, and the details of work carried out.

(a) Numbers Provided with Dental Care.

	Examined.	Needing Treatment.	Treated.	Made Dentally Fit.
Expectant and Nursing Mothers	260	257	231	116
Children under five	937	331	331	281

(b) Forms of Dental Treatment Provided.

	Extractions.	Anaesthetics: Local	Anaesthetics: General.	Fillings.	Scaling or scaling and gum treatment.	Silver Nitrate treatment.	Dressings.	Radiograph.	Dentures Provided: Complete.	Dentures Provided: Partial
Expectant and Nursing Mothers	300	156	8	180	85	—	145	21	62	33
Children under five	208	49	63	114	—	57	51	5	—	—

ORTHOPAEDIC TREATMENT.

As I pointed out in the report on the School Health Service, with which this matter is perhaps most closely associated, there has been a most disappointing falling off in the use made of our orthopædic clinics since the National Health Service Act came into operation. Numerically the numbers remain more or less the same. Orthopædic cases do require supervision for long periods, often for many years, and therefore we still have attending our clinics considerable numbers of old cases, both adults and children. So far as this report is concerned these are mainly cases of tuberculosis of the bones and joints or cases requiring supervision, treatment by plaster, and the renewal of appliances, but taken by and large the *new* cases that are coming along are very minor conditions such as flat feet and rickets.

This is disappointing because our orthopædic clinics are capable of acting as real clearing houses for orthopædic conditions, and should be able to relieve the congestion on the overcrowded orthopædic clinics at

the Cumberland Infirmary. Unfortunately the general practitioners as a whole are now by-passing our orthopædic clinics, and are sending cases direct to the hospitals, and the clinics are largely kept going by the minor conditions above referred to, ferretted out by our own medical staff at the school medical inspections and child welfare clinics.

I think this is a great pity, because not only does it mean that our orthopædic clinics have fallen materially in value and interest, but it means also that we know far less about orthopædic conditions in our children than we used to do, and it also undoubtedly means that our clinics are not playing the part they could play in relieving congestion at the hospitals. It must mean also that many people are put to the trouble of long journeys to Carlisle, who could quite easily and efficiently be dealt with in the field, at least so far as diagnosis is concerned, and to a considerable extent as regards treatment.

It is not difficult to understand why we have had no applications for the vacancies on our staff for orthopædic physiotherapists, for quite obviously these people are tending to gravitate to the hospitals because all the interesting work goes there.

Crippling conditions affecting children under five years of age.

Rickets	219
Flat Foot	69
Congenital defects	18
Club Foot	11
Injuries	5
Infantile Paralysis	11
Torticollis	9
Spastic conditions	6
Congenital Dislocation of Hip	11
Tuberculosis	4
Birth Palsy	10
Hallux Valgus and Deformed Toes	10
Scoliosis, Kyphosis, Poor Posture	7
Talipes and Pes Cavus	60
Other conditions	43
	493

Tuberculosis of the Bones and Joints.

	Adults.	School Children.	Children Under 5
Spine	41	11	3
Hip	19	4	—
Knee	9	6	—
Sacro-iliac Joints	5	—	—
Thigh	1	2	—
Wrist	2	—	—
Elbow	2	—	—
Shoulder	5	1	—
Ankle	5	—	1
Tibia	1	4	—
Foot	1	1	—
	91	29	4

Adult Non-Tubercular Cases.

Infantile Paralysis	19
Arthritis	19
Scoliosis	7
Congenital Dislocation of Hip	9
Flat Foot	6
Osteomyelitis	8
Vertebral Disc Protrusion	8
Hallux Valgus	7
Injuries	10
Spastic	4
Club Foot	4
Other conditions	21
	122

Table A.

Number on Aftercare Register, 1/1/49	436
New cases during 1949	279
Cases re-notified after discharge previously	2
Number removed from Register	212
Number remaining on Register at 31/12/49	505
Attendances at Aftercare Clinics	603
X-Ray Examinations during 1949	94

Table B.

Number of attendances at Aftercare Sister's Clinics	748
Home Visits	195
Plasters applied at Intermediate Clinics by Aftercare Sister	94
Plasters removed at home by Aftercare Sister	23
Surgical Boots and Appliances supplied	198

Table C.

Hospital Treatment.

Name of Hospital.	In Hospital 1/1/49.	Admitted during year.	Discharged during year.	In Hospital 21/12/49.
Ethel Hedley Hospital, Windermere	10	13	13	10
Shropshire Orthopaedic Hospital, Oswestry	12	9	12	9

VENEREAL DISEASES.

I am indebted to Dr. H. J. Bell, Consultant Venereologist, for the following extracts from his report to the Special Area Committee.

1. "Statistics.

The decrease in the incidence of venereal diseases, general throughout the country, is reflected in the continued decline in the numbers of cases of fresh venereal disease which were treated in the Cumberland Infirmary in the year 1949. The volume of work, as shown by the number of total attendances for treatment, also decreased. The situation is illustrated by the following figures:—

Year.	Clinic at Carlisle. Early Venereal Infections.	Total Attendances.
1945	156	5181
1946	201	5274
1947	139	3764
1948	94	3473
1949	69	3212

It will be noticed that the peak year was 1946, which was the peak year throughout Britain and America.

The results from the clinic at Whitehaven are in contrast, since 1949 produced an increase in the number of cases treated for early venereal disease and in the total number of attendances:—

Year.	Clinic at Whitehaven Early Venereal Infections.	Total Attendances.
1945	53	2304
1946	81	1821
1947	38	1362
1948	28	944
1949	44	995

Here the upward trend in 1949 is accounted for by a new population (approximately 1,600 men) in the labourers' camps at Sellafield and Nethertown. They come to the clinic in ever increasing numbers for advice. An analysis of cases attending the Whitehaven clinic for the first time during the year shows the relatively high number of men attending from these camps (15 per cent. of the total figure):—

Sellafield and Nethertown Camps ...	21
Whitehaven and nearby	30
Workington	34
Frizington	15
Other areas	42
Total	142

A further study of the origin of all the new cases which attended the clinics at Carlisle and at Whitehaven gives this table:—

Town or Area.	Carlisle Clinic.	Whitehaven Clinic.	Total.
Carlisle and Suburbs ...	155	—	155
Aspatria	8	—	8
Cockermouth	6	2	8
Dumfriesshire	20	—	20
Frizington	—	15	15
Longtown	5	—	5
Maryport	22	6	28
Penrith and area	38	—	38
Shap and Westmorland ...	6	—	6
Whitehaven	6	30	36
Wigton	13	—	13
Workington and area ...	18	34	52
Outside Cumberland area	36	—	36
Sellafield and Nethertown Camps	—	21	21
Other Areas (to Carlisle) ...	23	—	23
Other Areas (to Whitehaven)	—	34	34
	356	142	498

Here it is shown that Carlisle and its suburbs produce about one-third of all cases presenting themselves for advice at our V.D. clinics; it seems that one-third of the patients from Workington prefer to make the journey to Carlisle rather than go to Whitehaven which is so much nearer at hand; and it suggests that a number of patients from Whitehaven itself prefer to attend Carlisle rather than their local clinic; also illustrated is the incomprehensively large number of cases from Frizington.

2. Treatment.

Modern research in venereal disease is producing a revolution in treatment almost as fantastic as the atomic bomb in the conduct of war. Gonorrhœa is cured in a matter of hours by one injection of penicillin procaine, and the complications of the disease will soon be a feature of text books alone. Urethritis yields to tiny doses of streptomycin. The treatment of early syphilis has once again become an out-patient routine; penicillin is given by daily intra-muscular injection. Although opinion is that this country is as yet unable to accept the abandonment of arsenic altogether in the treatment of early syphilis, there is little doubt that in time its use will be discontinued. All clinicians would prefer to give up the use of N.A.B. It is the stronger arsenical preparations of the N.A.B. type which occasionally cause severe complications and death during treatment. Penicillin has allowed the clinicians to substitute the arsenoxides which seldom cause toxic reactions. The aim to dispense with arsenic altogether, and thus with intra-venous therapy, is the next logical step. The use of weekly intra-muscular injections of penicillin procaine and bismuth alone has been initiated in various parts of the country, and a carefully controlled experiment of this kind is being made at Whitehaven. Such a method of treatment, if it proves successful, might well hand back to the care of the general practitioner the treatment of cases of early syphilis, and if a diabetic may be allowed to inject himself with insulin, what next?

The most dramatic results of penicillin therapy of syphilis are, of course, in the treatment of the pregnant syphilitic mother. Given at almost any stage of pregnancy after the fourth month the outcome is the birth of a non-syphilitic child in 97 per cent. to 98 per cent. of cases. Likewise in the neo-natal period of a syphilitic infant's existence penicillin (with a mild adjuvant treatment) will guarantee survival and cure.

It is these advances in the knowledge of the disease which prompt me to suggest that attention should be transferred from treatment of cases to prevention of the disease. In this respect the importance of a close liaison between the venereologist and the medical officer in charge of ante-natal clinics cannot be overemphasised, and likewise the work of the lady almoner

and other agencies employed in follow-up and contact tracing becomes of first importance.

3. Clinic at Cumberland Infirmary.

I regret that it has not been possible to provide beds for V.D. cases in the Infirmary. One female bed in Hut 1 is available when required for a female patient, but there is no provision for men or for children. Apart from more obvious drawbacks, the absence of facilities for treating bed cases deprives a clinician of much of the normal interest of his work, and reduces his opportunities for study and research.

The Lady Almoner (Miss Buck) continues to give the most valuable help to the Medical Officer with the time at her disposal.

Accommodation: The ever-changing methods of treatment and of clinic organisation have made the irrigation room a waste of space. I should like to convert this into a male examination room, where in addition minor operative procedures could be carried out and where the male orderly could prepare his syringes for the new syringe service.

There is great difficulty in dealing with cases who have undergone lumbar puncture. It is very inconvenient to put up beds in the waiting room to rest these cases after the procedure, as is the case at present. The acquisition of the nearby room in use by the House Physician would solve this difficulty. With the present method only four lumbar-punctures can be carried out each week.

4. Clinic at Whitehaven.

The premises are very unattractive. The Medical Officer becomes inured to working under conditions of darkness and difficulty, but there is little to attract patients to continue their attendance. The drawbacks at this clinic have been reported almost every year by Dr. McMurtrie. The compensating feature is the cheerfulness and enthusiasm of Miss Wilson, the sister-in-charge, and her staff. No structural modification of the premises will effect any improvement.

It is in such adverse conditions that the cheerful encouragement of a well trained almoner is of such importance in the treatment of V.D. patients. Miss

King has now resigned her post, and I suggest that a successor, as capable as she was, be appointed as soon as possible. Her work in this difficult industrial area is as important as that of the Medical Officer himself.

5. Workington.

Reference to paragraph (1) of this report indicates that the numbers of civilian patients attending Whitehaven clinic from Whitehaven and Workington are the same. Some, for personal reasons, travel to Carlisle from both places. I do not suggest that the out-patient department be transferred from Whitehaven to Workington, especially since an ever-increasing number of new patients are reporting from the workmen's camps at Seascale and Nethertown; moreover the total numbers reporting from the area are not sufficient to justify the establishment of a weekly session at both Workington and Whitehaven. The average weekly attendance at Whitehaven is only 18-19 patients.

The problem of the treatment of seamen is one to be treated apart from the local civilian population. These men are mostly from ships on a short turn-round from the North African coast; the cargo is pig iron. They are such a short time in port that the establishment of a dock-side clinic would prove a white elephant, unless it was served by a medical officer prepared to attend at all hours of the day. This has been proved elsewhere in the country. Some men will inevitably report at the Workington Infirmary and arrangements to deal with these cases must be made (only three patients have reported during the last six weeks). The most practical and efficient solution is the selection of a general practitioner who is both enthusiastic and efficient in the task of treatment of seamen suffering from venereal disease. The success of such a scheme, I would point out, depends on the practitioner himself. Hitherto Dr. Edwards had treated seamen at Workington, and his successor in the practice is Dr. H. A. K. Rowland. Dr. Rowland was an accredited V.D. Specialist in the R.A.F. for two years and was trained in St. Mary's Hospital, London, by Dr. G. H. McElligott, who is Adviser in V.D. to the Minister of Health. I suggest that he be recognised as an Approved Practitioner under the M.O.H. Circular 2226 of 1940.

During 1949 Dr. Rowland's statistics are reported as follows:—

Fresh Cases reporting at Surgery:

Seamen	185	
Civilians	20	
		Total 205

Of the Patients who were not seamen:

Fresh gonorrhoea	6	
Early secondary syphilis ...	2	
Others	12	
		Total 20

Of the Patients who were seamen:

Fresh gonorrhoea	134	
Fresh syphilis	4	
Other cases and continuation treatment	47	
		Total 185

I have arranged a scheme with the Surgical Registrar at Workington Infirmary, so that the occasional patient reporting for V.D. treatment may be attended to. Some pages of instructions have been typed and all necessary drugs have been provided."

CANCER

Deaths from cancer during the year amounted to 383, which is the highest figure ever recorded for the administrative county. Details of these deaths by age groups and sanitary districts are given below, and call for no comment.

Cancer Deaths during 1949—By Sanitary Districts.

	Males.	Females.	Total.
Urban Districts:			
Cockermouth	2	10	12
Keswick	2	5	7
Maryport	17	9	26
Penrith	16	14	30
Whitehaven	18	19	37
Workington	24	33	57
Aggregate of Urban Districts	79	90	169
Rural Districts:			
Alston	3	2	5
Border	22	27	49
Cockermouth	14	15	29
Ennerdale	33	25	58
Millom	10	17	27
Penrith	7	8	15
Wigton	15	16	31
Aggregate of Rural Districts	104	110	214
Whole County	183	200	383

Cancer Deaths during 1949—By Age Groups.

	15—45		45—65		65+		All Ages Totals	
	M.	F.	M.	F.	M.	F.	M.	F.
Urban Districts	4	6	26	35	49	49	79	90
Rural Districts	10	4	38	43	56	63	104	110
Whole County	14	10	64	78	105	112	183	200
	24		142		217		383	

The hospital side of this matter is, of course, one for the Special Area Committee, but it is of interest to record that treatment by deep X-ray therapy opened at the Cumberland Infirmary in June, 1949. Two deep X-ray therapy plants have been installed, but the accommodation is by no means adequate, and this may hinder the recruitment of staff, particularly at the specialist level, which is nationally in short supply, as is the case also with other technical officers, especially radiographers and physicists. At present the department is in the charge of a resident senior registrar, with supervision from Newcastle.

A general picture of the work undertaken at the Cumberland Infirmary is given in the following statistics, for which I am indebted to the Secretary of the East Cumberland Hospital Management Committee. As will be seen some of the figures refer to cases other than those from the administrative county, but as these are of general interest I have also included them.

Number of Cancer Cases attending the Cumberland Infirmary as Out-patients during 1949.

	First attendance.	Subsequent attendance.
County cases	126	1,385
Carlisle cases	25	685
Other districts	7	261
		2,331

Number of Cancer Cases admitted to the Cumberland Infirmary during 1949

County cases	173
Carlisle cases	89
Other districts	44
	306

In the above table the 173 county patients were made up of 141 new cases and 32 old cases or re-admissions. The apparent discrepancy between the number of new cases admitted as in-patients during the year and the number of first attendances as out-patients is explained by the fact that cancer patients may attend, undiagnosed as such, for investigation by other departments, usually the surgical department, but in some cases the medical department, or the eye or ear, nose and throat departments. Gynæcological cases are in the main referred to another centre in the region. Some cases, too, are referred to the radio-therapy department direct.

Between the opening of the radio-therapy department in June, 1949, and the end of the year, there were over 900 attendances, mainly for treatment, chiefly by deep therapy, but in a certain number of cases by superficial therapy. The figures for 1950 show that the treatments given have risen by leaps and bounds, and at the moment the average treatments per month amount to about 450, or at the rate of well over 5,000 a year. All this shows that there has been a dramatic increase in the number of cases investigated or treated in respect of malignant conditions at the Cumberland Infirmary within the past twelve months.

PREVALENCE OF, AND CONTROL OVER, INFECTIOUS AND OTHER DISEASES

During 1949 there was no epidemic of infectious disease of any significance in the county. Most of the figures, in fact, fell substantially from the 1948 figure. Measles, for example, dropped by nearly 2,000. During the year notifications were received of 31 cases of infantile paralysis. I doubt if the number of confirmed cases was really as high as this, but certainly there were one or two periods during the year when we appeared to be on the verge of another outbreak on the 1947 level. Very fortunately no such extensive outbreak materialised. Contact with Medical Officers of Health on this question of notification of infectious disease proved unsatisfactory or incomplete on a number of occasions, and in connection with a number of diseases. I received in fact a number of complaints from Medical Officers of Health of sanitary districts

in this connection and frankly I think the hospitals were to blame.

I imagine the position was not peculiar to Cumberland and that is one of the reasons why the Ministry issued in March, 1950, Circular No. HMC(50)21 concerning the transmission of information from hospitals to Medical Officers of Health, to which reference is made elsewhere in this report. A considerable part of this circular is devoted to the notification of infectious disease to Medical Officers of Health. I think the steps I was able to take locally during the year will prevent a recurrence of this difficulty. There is no doubt that prompt notification, from whatever source, is essential —and that may mean the medical practitioner, general hospital, or an infectious diseases hospital — if the Medical Officer of Health is to do his statutory duty and play his part in the control of infectious disease.

Once again no case in the enteric fever group was reported, and it is interesting to note that the number of notified cases of diphtheria fell to two, neither of which was fatal. When one remembers that about ten years ago we had well over 300 cases of diphtheria in one year *with* 18 *deaths* we must be thankful for the benefits which the Ministry's policy of immunisation have conferred on the community.

Perhaps a word on the work being undertaken by the Special Area Committee on the modernisation of the isolation hospitals would be of interest.

The former isolation hospital at Crozier Lodge, Carlisle, now incorporated in the Cumberland Infirmary as its isolation block, and Galemire isolation hospital in West Cumberland are both being re-constructed on a cubicle basis. This will enable much better segregation of patients and will enable many more infectious conditions to be admitted at the same time, and will, in fact, mean that a smaller number of beds will be able to do much more effective work. The isolation hospital at Ellerbeck in Workington is being closed as such, and is in the process of conversion into a general medical and surgical annexe to Workington Infirmary. A few cubicles have been provided at Penrith isolation hospital.

This policy of modernising the isolation hospitals on a comparatively small bed basis is really comparable

to maintaining a small but highly mechanised army. The reduction, on paper, of isolation hospital beds which has taken place in the last 10 to 15 years is so large as to seem fantastic, but one has to remember that at that time the isolation hospital position though numerically large was medieval. Cubicles did not exist. The buildings were geographically badly placed, badly constructed, and in a poor state of repair, and there is no doubt that the position is becoming much tidier and infinitely more efficient.

As a matter of interest I set out below the records of deaths from the commoner infectious diseases in respect of the past few years.

Scarlet Fever.

In 1944	there	were	324	cases	with	1 death.
In 1945	„	„	369	„	„	0 deaths.
In 1946	„	„	152	„	„	0 deaths.
In 1947	„	„	150	„	„	0 deaths.
In 1948	„	„	189	„	„	0 deaths.
In 1949	„	„	182	„	„	0 deaths.

Diphtheria.

In 1944	there	were	195	cases	with	11 deaths.
In 1945	„	„	69	„	„	2 deaths.
In 1946	„	„	73	„	„	2 deaths.
In 1947	„	„	8	„	„	1 death.
In 1948	„	„	13	„	„	0 deaths.
In 1949	„	„	2	„	„	0 deaths.

Enteric Fever.

In 1944	there	were	2 cases with 2 deaths.
In 1945	„	„	Nil.
In 1946	„	„	2 cases with 1 death.
In 1947	„	„	Nil.
In 1948	„	„	1 case with 0 deaths.
In 1949	„	„	Nil.

Measles.

In 1944	there	was	1 death.
In 1945	„	were	2 deaths.
In 1946	„	„	0 deaths.
In 1947	„	„	3 deaths.
In 1948	„	„	3 deaths.
In 1949	..	..	5 deaths.

Whooping Cough.

In 1944 there were 8 deaths.
In 1945 „ „ 5 deaths.
In 1946 „ „ 4 deaths.
In 1947 „ „ 3 deaths.
In 1948 „ „ 5 deaths.
In 1949 „ „ 8 deaths.

Cerebro-Spinal Fever.

In 1944 there were 11 cases with 3 deaths.
In 1945 „ „ 11 „ „ 5 deaths.
In 1946 „ „ 13 „ „ 4 deaths.
In 1947 „ „ 10 „ „ 2 deaths.
In 1948 „ „ 6 „ „ 2 deaths.
In 1949 „ „ 3 „ „ 3 deaths.

Infantile Diarrhoea.

In 1949 there were 10 deaths under 2 years of age.

NOTIFICATION OF CASES OF INFECTIOUS DISEASES IN THE COUNTY OF CUMBERLAND DURING THE YEAR 1949.

DISTRICT	Scarlet Fever	Whooping Cough	Diphtheria	Measles	Pneumonia	Polio-myelitis	Enteric Fever	Erysipelas	Polio-encephalitis
URBAN DISTRICTS									
Workington	21	74	1	93	21	—	—	7	—
Whitehaven	6	7	—	5	22	1	—	1	—
Cockermouth	6	—	—	—	—	1	—	—	—
Keswick	2	—	—	—	1	—	—	1	—
Maryport	8	11	—	2	1	—	—	1	—
Penrith	11	75	—	11	19	3	—	2	—
RURAL DISTRICTS									
Alston	2	4	—	3	6	—	—	—	—
Border	76	43	—	288	5	3	—	1	1
Cockermouth	3	25	—	31	12	1	—	3	—
Ennerdale	11	45	1	85	8	6	—	3	—
Millom	4	22	—	2	14	2	—	17	—
Penrith	19	77	—	51	23	6	—	1	1
Wigton	13	64	—	86	26	8	—	11	—
Totals	182	447	2	657	158	31	—	48	2
1948	189	622	13	2362	114	7	1	49	—
1947	150	286	8	1960	147	74	—	41	—
1946	152	418	73	591	138	3	2	47	—

INSPECTION AND SUPERVISION OF FOOD.

Foods other than Milk.

The report of the County Analyst is not included as this has already been circulated to the County Council.

No epidemic of food poisoning of any significance occurred in the county during the year under review.

Milk.

When I wrote the annual report for 1948, I envisaged the future position as likely to involve, arising out of the milk regulations of one kind and another issued during 1949, the disappearance of any reference to milk in future annual reports. It was anticipated that the whole responsibility for milk sampling and supervision generally would be transferred from local health authorities to the Ministry of Agriculture, or possibly to more than one Ministry acting in co-operation. The actual regulations, however, when they appeared, put a somewhat different complexion on the matter.

The regulations are complicated—very complicated—and would appear to be the result of compromise. Their purpose is not very easy to understand, but the general trend seems to have a commercial rather than a public health basis. In other words, the target seems to be the keeping quality of milk rather than the protection of the public health. As one comment put it: "The share of the Ministry of Health is reduced to the role of a very junior partner." *

Some further analysis of these regulations is obviously desirable. The chief change is the transfer from local health authorities to the Ministry of Agriculture of the duty of issuing licences for graded milks and the keeping of milk produced under these licences up to scratch by routine sampling. For the future, all bacteriological sampling—other than biological sampling for tubercle and one or two minor matters—will apparently be the duty of the Ministry of Agriculture. Apparently, too, this sampling in the main will be done at collecting depots, and even there very largely *by the trade* on behalf of the Ministry, which seems, to say the least, a strange arrangement. I think, although I am not sure, because the matter has passed out of

* "Public Health," January, 1950.

my province, that this sampling will be in the main in respect of *graded* milks.

Local sanitary authorities have still some small duties in respect of the registration of milk distributors and their premises, other than producer-retailers, and medical officers of such authorities have certain duties in connection with the control of milk-spread infectious disease.

What will take the place of the sampling at the *source of production* which we as a health authority have undertaken on a large scale over the years, and how the routine work of the sanitary inspectors in their respective districts in examining premises and supervising methods of production can be conveniently and economically replaced, I do not know. These men were on the spot, and they took these matters in their stride.

So far as county councils are concerned, they have left to them some small duties in respect of granting of pasteurised licences (of which there are two in Cumberland) and of the taking of routine samples of pasteurised milk. They may also have, in the future, as plants are established, similar duties in connection with sterilised milk. At present there are no sterilised milk licences operating in Cumberland. All powers of cancellation of licences for designated milks and all powers of withholding these licences are now withdrawn from county councils.

The main duty left to county councils lies in the matter of sampling for tubercle under Section 25 of the Food and Drugs Act, 1938. No Ministry seems to be interested, and it is apparently left to county councils to do as much or as little sampling for tubercle as they fancy. Nor do the regulations show any interest in the very important question of protecting the very large number of people in rural areas who consume the milk—frequently ungraded and seldom, if ever, pasteurised—which is distributed in small milk rounds in rural villages and hamlets. It is estimated that in this county there must be something like 600 of these ungraded producer-retailers with small milk rounds, and that means thousands of people, including children, whose interests must be safeguarded. It is felt by some, probably with reason, that as more and more herds become attested, reacting cows will tend to gravitate down into these ungraded herds supplying small local milk rounds. The risk is obvious and it is at least

curious that with three Ministries and something like twelve different bodies in all having some duties or powers in connection with the production and consumption of milk, no body seems to have placed upon it by these regulations any clear directive as to the supervison and safety of these large quantities of milk consumed locally in rural areas.

I should like to refer to the very important memorandum issued jointly by the British Medical Association and the National Veterinary Medical Association under the title of "The provision of Safe Milk of High Quality." This memorandum is extremely valuable, but unfortunately it did not appear until after the new milk regulations were issued in the autumn of 1949. The recommendations in this memorandum differ widely from the regulations. It seems strange that the parties concerned in the preparation of these two important sets of documents, the regulations and the memorandum, both apparently sitting concurrently, do not appear to have been aware of each others activities or to have conferred together.

Following upon the issue of the regulations, a local conference was held at officer level, representing the sanitary authorities, the Ministry of Agriculture, the Cumberland Agricultural Executive Committee, the laboratory services and the County Council, to consider the regulations, and to make recommendations. Arising out of this conference and out of the labours of a small sub-committee appointed by the conference, certain recommendations were drafted and were subsequently approved by the County Council and later by a further conference between representatives of the County Council and members of the local sanitary authorities in the county. These recommendations were as follows:—

(1) *Sampling for tubercle should be discontinued in respect of tuberculin tested and attested herds but should be continued by the County Council in respect of accredited and ungraded herds, in so far as milk from these herds is consumed in Cumberland and is not pasteurised.

(2) Such testing for tubercle in respect of accredited and ungraded herds (the milk from which is consumed in the County and is not pasteurised), should be undertaken twice a year.

(3) The County Council should seek the co-operation of the local sanitary authorities in the carrying out of sampling under (1) and (2) above.

* See Note on Page 80.

(4) Sampling for cleanliness so far as the County Council is concerned should be suspended for the present. If these supplies are designated milks they will be sampled for cleanliness by the Ministry of Agriculture. Ungraded milk supplies which are the subject of complaint should be sampled for cleanliness by the appropriate local sanitary authority.

(5) Sampling records in the possession of the Ministry of Agriculture, the County Council, or local sanitary authorities should be interchangeable on request.

(6) The County Council being responsible for the actual cost of the carriage of samples to the laboratory, payment for the collection of samples should be at the rate of 3s. 6d. per sample, with, in rural areas, mileage as incurred on the Whitley Scale casual user rates, and in urban areas mileage as above, or actual out of pocket expenses, the County Council requesting the local sanitary authorities to transmit these payments to the sanitary inspectors concerned in the collection of the samples.

The main purpose of these recommendations is obvious, namely, to protect the consumers of accredited and ungraded milk (not being pasteurised), within the County, from the risks of tubercle-infected milk. These recommendations were supplemented by instructions drafted by the Pathologist, the Divisional Inspector of the Ministry of Agriculture and the Chief Sanitary Inspector of the Border Rural District with regard to:—

(a) Directions for sampling and the transport of samples to the laboratory.

(b) Setting up a sort of time table to prevent the laboratory becoming overwhelmed at any given time with an overplus of samples for biological investigation.

Of the six recommendations above made by the committee, No. 5 is not the least important. It is clear that, when sampling undertaken by whatever body reveals the presence of tubercle or bacteriological contamination of other kinds liable to be a menace to health, there should be complete and prompt interchange of information between the interested parties.

The last thing I want to say before coming to a few statistics in respect of the year under review, is to refer to the establishment of county milk and dairies advisory committees. One of these committees is to be set up for each administrative county and the county council is entitled to *nominate* for the Minister's approval, one person to represent the interests of the Council. These committees are apparently to be "charged with the duty of keeping under review the operation and administration of the Milk and Dairies

Regulations and the Milk (Special Designation) (Pasteurised and Sterilised) and (Raw Milk) Regulations." This would seem to mean *inter alia*, that the County Council, having for many years maintained a very active and progressive milk and dairies committee which dealt annually with thousands of samples and hundreds of licences *without supervision*, is now to be supervised by this advisory committee in respect of the small fragment left to it in the matter of pasteurised and sterilised milk licences. All this seem to me to be very peculiar.

In presenting a few statistics for the period under review, I have quite deliberately omitted any reference to testing for cleanliness, in connection with which, up to the 30th September, 2,176 samples were collected. Any analysis of the results would now seem to be unprofitable. All sampling except in respect of pasteurised milk ceased on the 30th September, and remained in abeyance for several months. This was necessary in order that it could be determined how our remaining duties as a county council could best be administered. Sampling in respect of tubercle only has now, at the time of writing (May, 1950), been resumed under the arrangements, outlined above, with the local sanitary authorities.

During the year, and up to 30th September, 867 samples were investigated biologically in respect of tubercle, and of these, seven were found to be positive, showing a positive percentage of 0.81. Figures for some previous years are given below. Arising out of these seven cases, which were, of course, all reported immediately to the Divisional Inspector of the Ministry of Agriculture, five cows were found to be affected with tuberculosis and were slaughtered. The remaining two cases were connected with two cases occurring towards the end of the previous year, and no further action was necessary.

The following details refer to samples examined for Tubercle.

Year.	No. submitted to the Biological Test.	Percentage Positive for Tubercle.
1943	1323 ...	2.04%
1944	1273 ...	1.6 %
1945	1112 ...	0.99%
1946	1245 ...	1.3 %
1947	1125 ...	0.7 %
1948	1171 ...	0.77%
1949	867 ...	0.81%

In view of the fact that our future sampling for tubercle in this county is to be confined to accredited

and ungraded herds, I think it is certain that the percentage of positive samples will rise, possibly fairly steeply.

Under the old Milk (Special Designations) Regulations, four licences were revoked during the year up to 30th September. It is perhaps interesting to note that at the time we handed over our duties there were 648 tuberculin tested licences in operation in the county and some 1,400 attested herds. These figures, of course, to a large extent overlap.

During the period under review, 62 samples of pasteurised milk were collected for examination, of which 44 were satisfactory and 18 unsatisfactory.

School Milk Supplies.

The usual reference to the cleanliness of school milks collected up to the time of the change-over is omitted, as it hardly seems worth while giving the figures, but it is worth recording that 150 samples of school milk were examined during the year for tubercle, and of these, one sample from an ungraded herd proved positive for tubercle. The cow responsible was immediately detected and slaughtered.

Veterinary Inspection of Dairy Herds.

I am again indebted to Mr. Reid, Divisional Inspector of the Ministry of Agriculture for this area, for the following figures relative to the results of inspections of dairy herds, and also to the number of cattle which have been slaughtered under the Tuberculosis Order in the county during the year.

Number of confirmed cases of tuberculosis ... 65

Clinical Inspection of Dairy Herds.

Class of Herd.	No. of Herd Inspections.	No. of Cattle Examined.	No. of Cattle dealt with under the Tuberculosis Order.
Tuberculin Tested	790	45,889	5*
Accredited	106	3,139	11
Ungraded	2,550	43,441	49

Tuberculin Testing of "Tuberculin Tested" Herds.

Number of cattle tested	49,122
No. of reactors found	141

**The finding of five tuberculous cows in tuberculin-tested herds is disturbing. Actually, there were two such cows in one herd. This makes one wonder whether recommendation (1) on page 77, may not have to be amended at some future date in the light of experience.*

HOUSING

At my request the County Architect has briefly reviewed the housing position as it affects the County Council, and as it will affect the County Council, under an expanding programme for the provision of staff houses of one kind and another.

"The accommodation for which the County Council is responsible includes not only new houses, but flats resulting from the conversion of existing houses, and also many older houses which have been bought or inherited by the Council from time to time. The total number of houses owned by the Council is approaching 300, and it would appear likely that this figure would increase in future at an expanding rate. As an example, two new classes of County Council tenants have now appeared—firemen and district nurses. Furthermore, the Council, in connection with the problem of recruitment of staff, have had to embark on a programme of house construction for the purpose of providing housing accommodation largely for new members of the staff, and largely among these for the less well paid and younger members of the staff. The present proposal is to erect 24 houses for this purpose. The first instalment of six houses at Scotby is approaching completion, and the first tenants will have moved in before this report appears. Further instalments are envisaged at Wetheral and in West Cumberland.

A group of thirteen firemen's houses around the future drill yard of the fire station at Workington have been planned, and building operations are expected to start during the next few weeks. It will be appreciated that in a 24-hour operational service, manned largely by part-time personnel, the difficulty of summoning firemen from their homes constitutes a major problem which can only be solved satisfactorily by housing the firemen very close to the station where they serve.

Realisation of the large police housing programme in the county is now becoming visible to travellers passing through many of the villages. Twenty-one of the post-war houses are now in occupation, and a further thirty-five are in varying stages of building operations. It will be recollected that one of the conditions laid down by the Home Office after the war was

that the houses should be built to a standard plan, so that, when police officers are necessarily, in the course of their duties, moved from one station or house to another, their furniture, curtains, carpets and other furnishings would be interchangeable. Cumberland has been particularly successful in arranging that the rural stations and the police houses in the urban areas meet these requirements.

The new schools now being erected are going to play such an important part in the cultural activities of the adult population, quite apart from their use as day schools, that the problem of caretaking is very real. It would appear to call for resident caretakers. So far sanction has been received for the erection of one pair of semi-detached houses for caretakers at Maryport Primary School. A caretaker's flat has been contrived in the existing mansion on the Lairthwaite school site."

The County Architect in his note made a reference to housing for district nurses, but as this is very much a health department problem, I would like to say something about it in my own words.

Now that we have taken over direct administration of the district nursing services it becomes the direct responsibility of the Council to see that our nurses are adequately housed. During recent years the County Nursing Association made considerable progress in this matter of housing so far as district nurses were concerned in co-operation with the sanitary authorities of the county, but much remains to be done, and with this object in view, and bearing in mind that health visitors and whole-time midwives, as well as district nurses, require to be adequately housed, the Nursing Sub-Committee, at their first meeting, approved a schedule, of which a copy is attached, showing the proposed developments contemplated as likely to take place within the next few years on a three-stage programme. The schedule shows that some houses will be for the use of one nurse, some for the use of two nurses. Garages for one or more cars will be provided where appropriate. The houses provide three bedrooms, and considerable discussions has centred round this point. I am satisfied that a three-bedroomed house is essential, partly because in a re-arrangement of

districts one never knows when it may become desirable for two nurses to live together, and partly because among our nurses we have quite a number, particularly among the younger women, who have their fathers and mothers living with them, and we have a number of married nurses, or widows with families, involving bedroom accommodation for growing boys and girls. For all these reasons a three-bedroomed house in my view is essential, and the plain fact is that if facilities of this kind are not available, in many cases the appointments could not be filled.

In the case of houses for district nurses there is provision for a small treatment room with waiting accommodation.

The first stage in the programme set out in the schedule which follows will, of course, be to secure appropriate approved sites, and steps to this end, in conjunction with the County Architect and the County Planning Officer, are in hand.

PROGRAMME FOR THE BUILDING OF HOUSES FOR NURSES

Stage I.		Stage II.		Stage III.	
District Nurses * or Midwives.	Health Visitors.	District Nurses * or Midwives	Health Visitors.	District Nurses * or Midwives	Health Visitors.
Bewcastle Area. Suggested erection Roadhead or Sleetbeck.	Penrith.	Bothel.	(B) Whitehaven. On Valley Estate.	Threlkeld.	(B) Workington. Central.
(A) Longtown.	Cleator Moor. (Garage accommodation in each case for one car.)	Irthington.		Culgaith.	
Caldbeck.		Hayton (How Mill).		Houghton.	(B) Whitehaven. Bransty.
(A) Frizington.		(A) Egremont.		Lamplugh.	
Cleator Moor.		Wigton.		Southwaite.	
Nenthead.		Allhallows.		Parton.	
(A) Whitehaven. Valley Estate.		Seascale.		Millom.	
Burgh-by-Sands.		Maryport.		Oughterside.	
		Netherton Estate or Ellenborough.			
		(A) Workington. On Moorhouse Estate.			
(8)	(2)	(9)	(1)	(8)	(2)

NOTES—(A) Each of these houses to be a house for two nurses with garage accommodation for two cars.
(B) Each of these houses to be a house for two health visitors with garage accommodation for one car.
* Each house should be provided with a small surgery.

WATER AND SEWERAGE SCHEMES

(A) Water

Major Schemes

(1) North Cumberland Water Board Caldew Head Scheme.

The approval of the Ministry of Health to the commencement of this scheme is still awaited.

During the year there have been serious shortages of water in the rural areas of North Cumberland, and in the towns there has been great difficulty in maintaining proper and adequate supplies. In particular the supply position at Penrith has become so acute that the Urban District Council have found it necessary to sanction the cutting off of supplies at night, a most serious matter for hospitals, homes, institutions, and other premises.

In the summer of 1949 the Ministry of Health suggested a scheme to supply Penrith Urban District and Border and Penrith Rural Districts by intake from Caldew Head. This was not acceptable to the Water Board, as no supplies would be available to the other constituent authorities (Maryport and Cockermouth Urban District Councils and Cockermouth Rural District Council), and a deputation was sent from the Board which was received by the Parliamentary Secretary to the Minister of Health in October to stress the urgent need of the scheme. Later in the year Mr. Wilfrid Roberts, then Member of Parliament for North Cumberland, had two interviews with the Minister seeking the early progress of the scheme, which resulted in the Board being asked to submit revised proposals for reconsideration by the Ministry.

It is to be hoped that the Board's revised scheme will receive early ministerial approval and that the work will be commenced at an early date.

(2) Ennerdale Scheme.

The revised scheme has been approved in principle by the Ministry of Health, and it is understood that work on the scheme is about to commence. The Ennerdale Rural District Council have not, however, forwarded details of the revised scheme for the observations of the County Council or made an application for a County Council grant.

Local Schemes

During the year three schemes for the improvement of local water supplies have been submitted to the County Council for their observations under the Rural Water Supplies and Sewerage Act, 1944. These were as follows:—

Border Rural District Council ...	1
Millom Rural District Council ...	2

The estimated cost of the above three schemes is £57,110. With regard to the scheme submitted by the Border Rural District Council, the County Council were of the opinion that the scheme appeared sound and adequate subject to the submission of any revised proposals resulting from consultations with the Ministry of Agriculture. The two schemes submitted by the Millom Rural District Council were approved by the County Council subject to certain modifications being carried out. In one of these cases the Minister of Health had intimated that he was unable to make a grant towards the cost of the scheme under the Rural Water Supplies Act, 1944, as it appeared that the locality was already served by a piped water supply, and that the purpose of the scheme was to extend this supply to new houses to be built by the Council. In view of the Minister's decision, the County Council informed the District Council that they would be unable to make a grant under the provisions of that Act. The Minister of Health intimated that he was prepared to make a grant of £1,500 towards the cost of the Holme Beck, Loweswater Scheme, put forward by the Cockermouth Rural District Council, and the District Council were informed that the County Council would also make a grant towards the cost of this scheme.

(B) Sewerage

During the year one sewerage and sewage disposal scheme was submitted by the Millom Rural District Council for the observations of the County Council in accordance with the Rural Water Supplies and Sewage Act, 1944. The County Council approved this scheme subject to certain amendments, but the Minister of Health intimated that he was not prepared to make a grant in this case. In view of this the County Council

informed the District Council that they were unable to make a grant.

Information was received during the year from the Minister of Health that in the case of three schemes submitted by the Border Rural District Council he had decided to defer consideration of the application for grant. In the case of a scheme submitted by the Ennerdale Rural District Council the Minister informed the District Council that he was not prepared to make a grant in view of the small burden which would be imposed on the rates if the cost were met from local resources. In view of this, the County Council informed the District Council that they would be unable to make a grant.

Two schemes from the Cockermouth Rural District Council, and one from the Millom Rural District Council were completed during the year, and arrangements were made for the Council's grant to be paid.

AGENCY ARRANGEMENTS

The agency arrangements outlined in last year's report have varied in some important particulars. Perhaps it is as well to repeat that we are involved in agency arrangements from two angles, the first being where we arranged with voluntary bodies, or individual persons, to undertake certain duties on behalf of the Council. The other group is much smaller, and concerns certain agency arrangements which we undertake on behalf of the Special Area Committee.

(a) In the former group, the position is as follows:—

1. The agency arrangements with the Cumberland Nursing Association and the Penrith District Nursing Association continued to the end of the year. The agency arrangements with the Cumberland Nursing Association terminated on the 31st March, 1950, from which date the County Council will administer the nursing services direct. At the moment of writing the agency arrangements with the Penrith District Nursing Association continue.

2. With regard to the ambulance and sitting case car service, the agency arrangements as set out last

year continued to the end of the year, but early in 1950 the agency arrangements at Whitehaven ended, and, as mentioned elsewhere in this report, a direct contract was entered into with a private firm in respect of the ambulance service in that district. Similarly in Workington the agency arrangements terminated early in 1949, and the ambulance service is now dealt with by private contract.

3. The arrangements with the Carlisle Diocesan Council for Social and Moral Welfare, and the Lancaster Diocesan Protection and Rescue Society, in connection with the care of unmarried mothers and their children, at St. Monica's and at Brettargh Holt, Kendal, still continue.

4. As regards mental health, the arrangements with the Cumberland and Carlisle Mental Welfare Association terminated, as noted elsewhere in this report, on 30th November, 1949.

5. The arrangements with the British Red Cross Society in respect of the hospital car service continue and in the near future are likely to extend substantially.

6. The Carlisle Workshops for the Blind continued to the end of the year to act as our agents in respect of the care of the blind under the National Assistance Act. At the moment of writing the question of whether or not the home teaching and domiciliary sides of this work will continue on an agency basis as at present, or whether these will be taken over by the Council, is under consideration.

7. The arrangements under the National Assistance Act with the Diocesan Mission for the care of the Deaf and Dumb continue and the development of this service is under consideration.

8. During the year domiciliary nursing in the Alston area, excluding Nenthead, was undertaken on behalf of the Council by the East Cumberland Hospital Management Committee.

9. The agency arrangements with the Women's Voluntary Services in respect of the home help service terminated during the year.

(b) For the second part, the Council acted at officer level in respect of the tuberculosis dispensary service. This arrangement seems to me to be likely to continue in part, at least, for some time ahead, but a substantial part of the work has, at the time of writing, been taken over by the Chest Physician.

LABORATORY SERVICES

As noted last year we are fortunate in having in Carlisle a dual purpose laboratory doing public health work for the local authorities, under the auspices of the Medical Research Council, the clinical pathology for general practitioners and hospitals throughout the area, and milk and water samples for bacteriological investigation. We continue to be greatly indebted to Dr. Faulds, the Pathologist in charge, and to his staff, for advice on many occasions.

The laboratory has undertaken for us for many years milk sampling on a large scale, and I am afraid that their arrangements were somewhat upset at the end of September when, arising out of the new milk regulations, milk sampling closed down for the time being, with little notice. One of the important points, of course, concerned the stock of guinea pigs.

As noted elsewhere, pathological sampling for tubercle in connection with milk sampling was resumed in the spring of 1950.

The service we receive from the laboratory is not only of great value to us as a public health authority, but is without charge to the authority. The work of the laboratory is increasing substantially as is shown by the following table, which, of course, includes all specimens from whatever source received.

NUMBER OF SPECIMENS RECEIVED IN THE PATHOLOGICAL DEPARTMENT.

Year.	Milks.	Pathological Specimens.	Total.
1948	4,580	16,543	21,123
1949	3,877	22,134	26,011

Extensions of the laboratory buildings are now in progress, which will enable the staff to deal with the increasing turnover of specimens more conveniently than at present.

THE WELFARE SERVICES

I am indebted to the County Welfare Officer (Mr. Walker) for the following comprehensive report on the Welfare Services, the administration of which is in the hands of the Welfare Sub-Committee of the Health Committee.

NATIONAL ASSISTANCE ACT, 1948.

General.

As was stated in the Report for 1948 the general object of the above Act was to substitute for certain existing services a comprehensive scheme of assistance and welfare services which would complete the main pattern of the new social legislation, of which the Family Allowances Act, the National Insurance (Industrial Injuries) Act, the National Insurance Act and the National Health Service Act are other principal features. Whilst a fundamental object of the Act was to achieve the final break-up of Poor Law, and to create entirely new services founded on modern conceptions of social welfare, it can only be by the passage of time that such a desirable end can be fully and finally achieved.

Part III. Residential Accommodation.

Spectacular changes in the provision of Residential and Temporary Accommodation of different descriptions, suited to the different categories of persons who by reason of old age, infirmity and other circumstances, are in need of care and attention which is not otherwise available to them, cannot be accomplished overnight. Opportunities for acquiring suitable properties for adaptation as hostels for old people are becoming less and less frequent, and in Cumberland such properties as have presented themselves for possible acquisition have (so far with one exception) either been (a) too small or too large; (b) unsuitable for adaptation; or (c) situated in districts too isolated from the general centres of population.

The one exception is a small mansion known as Grange Bank, Wigton, which, with the approval of the Ministry of Health, has been purchased for use as a hostel for sixteen female residents. A tender has been accepted for the necessary works of adaptation, &c., and subject to these proceeding without any undue delay it is hoped that the new hostel will be in full use during the next financial year.

The estimated number of aged, infirm and handicapped persons for whom residential accommodation is required was given in the County Council's Approved

Scheme as 400. On the basis of hostels each of from twenty to thirty beds replacing the former Public Assistance Institutions, some thirteen to twenty hostels would be required to give full cover for the administrative county.

Whilst new buildings for this purpose may in due course be given fairly high priority, it is clear that the provision of such specialised accommodation on a scale adequate to meet the full needs of the county will take some time, and that in the absence of suitable buildings presenting themselves for purchase and adaptation former Public Assistance Institutions will have to be continued in use for the time being. With this fact in mind, and the added knowledge that not all the old people in the present establishments would be suitable for accommodation in hostels, the Welfare Committee has, during the course of the year, continued with various schemes for improving the standard of accommodation and amenities of the Institutions now used for Part III Residential Accommodation.

Hostel Provision for Short-Term Cases.

In connection with the provision of the new type of hostels for old people in need of care and attention, and whilst it is recognised that the ideal arrangement is for aged persons to be looked after in their own homes or in the homes of relatives willing to care for them, it may well be that the latter arrangement would result in relatives being unable to leave home for short respites or for annual holidays, owing to their inability to make suitable arrangements for the elderly persons to be properly cared for during their absence. To what extent this problem exists in the County of Cumberland is not yet known, but one would imagine there are many cases of the type in question, and efforts will be made in an endeavour to discover the extent of the problem. If there is a problem of any magnitude the answer would appear to be the provision of a short-stay hostel for aged persons in need of care and attention during a short period of one or two weeks whilst the relatives(s) or other person(s) looking after them is unable, owing to temporary illness or absence on holiday, to care for them. Ministry of Health Circular 87/48 in referring to the obvious advantages the new code has over the old, states that the objects which Parliament had in mind will not be achieved unless

those responsible for the administration of the new Act have the will and vision fully to seize the opportunities it gives them to substitute a modern welfare service for one which had perforce to be based on outmoded legislation for the relief of destitution.

If it should be acknowledged that such a problem or need does exist it would seem that advantage should be taken of the opportunity to make some provision for a short-stay hostel in the long term planning of hostels in that such a hostel might well be the means of encouraging relatives to continue to look after their elderly parents, and thereby avoid applications which might otherwise be made for the admission of relatives permanently to Part III Accommodation.

Present Accommodation and Hospital Facilities for Chronic Sick.

Part III Residential Accommodation is at present provided in three former Public Assistance Institutions, attached to which are small hospitals or sick ward blocks catering in the main for the chronic sick, together with a small maternity unit of three beds and three cots at Meadow View House, Whitehaven. The three establishments are:—

Establishment.	Number of Beds. Part III Accommodation.			Hospital.		
	Male.	Female.	Total.	Male.	Female.	Total.
Station View House, Penrith.	57	26	83	18	18	36
Highfield House, Wigton	42	17	59	24	21	45
Meadow View House, Whitehaven.	136	97	233	42	50*	92*
	235	140	375	84	89	173

* Includes small maternity ward of 3 beds and 3 cots.

As the predominant user of the three establishments prior to 5th July, 1948, was for other than hospital purposes, they remain wholly vested in the County Council.

Pursuant to the provisions of Paragraph 7 (1) of the 6th Schedule to the National Assistance Act, 1948, arrangements were entered into with the Regional Hospital Board whereby, until the Minister of Health otherwise determines, the beds in the hospital or sick

ward sections of the three establishments, to the total number of 173 (see details above) were reserved to the Regional Hospital Board for the maintenance and treatment of persons for whom the Board became responsible as from 5th July, 1948.

Due to the upgrading process of the Part III Accommodation (referred to under the previous heading) which in addition to the dividing up of some of the large dormitories and the better spacing of beds includes the provision of wardrobes, lockers, chairs, etc., it will be clear that the number of available beds will in due course be reduced. When the upgrading has been completed the Welfare Committee will be asked to agree a revised bed complement for each establishment. A similar position may arise later in regard to the number of hospital beds, but as at the present time the demand for hospital beds exceeds the number of beds available, any proposed reduction in the number of such beds would only be brought about by prior agreement with the Regional Hospital Board.

Two Committees (the Northern and Southern Area House Committees) are responsible to the Welfare Committee for the day to day management of the Part III Accommodation and separate accommodation reserved to the use of the Regional Hospital Board.

The following table shows the number of admissions discharges, and deaths during the twelve months ended 31st December, 1949:—

	Station View House, Penrith.			Highfield House, Wigton.			Meadow View House, Whitehaven.		
	Part III.	Hosp.	Total.	Part III.	Hosp.	Total.	Part III.	Hosp.	Total.
Admissions ...	30	48	78	43	123	166	181	222*	403
Discharges ...	28	19	47	40	70	110	162	129	291
Deaths ...	—	27	27	—	41	41	2	92	94
Residents and Patients maintained on 31/12/49. ...	36	31	67	51	34	85	148	85	223

* Included in this figure are 20 births.

Charges for Accommodation.

In accordance with the provisions of Section 22 (2) of the National Assistance Act, 1948, the County Council fixed 56s. per week as being the standard charge or

rate in respect of all Part III Residential Establishments, the rate to operate as from 1st October, 1949, and remain in force until reviewed by the Committee after considering the costing statement in respect of the financial year ending 31st March, 1950. During the year ended 31st December, 1949, and with the exception of 23 residents who have paid for the accommodation, &c., provided at rates between the minimum charge of 21s. per week and the standard charge of 56s. per week, the remaining residents have made payments at the minimum rate only, and the total payments made by residents in all three establishments during the twelve months ended 31st December, 1949, amounted to £12,225. In a few cases only did the respective Area House Committees find it necessary to write off as irrecoverable small outstanding amounts.

Monetary Recompense to Residents Rendering Assistance.

Rules adopted by the Welfare Committee for the management of Residential Establishment provide, inter alia, that residents will be expected, within their physical capabilities, to assist in preserving the cleanliness of the establishment by the performance of such tasks as they would reasonably expect to perform in their own homes, but where the appropriate House Management Committee consider, on the report of the Manager or Matron, that a resident gives voluntarily a substantial measure of regular assistance in the running of the Establishment, other than to his or her personal accommodation, the Committee is empowered to waive part of the payment due for the resident's accommodation, up to a maximum amount of 10s. 6d. per week for such period as the Committee may decide.

At the end of December, 1949, 42 male and 21 female residents were receiving remissions of 2s. 6d. or 5s. per week, having regard to the measure of regular assistance given. The total remissions or reduction in collections amounted to £11 5s. 0d. per week, or after the rate of approximately £585 per annum. The position in each case is reviewed monthly by the respective Area House Committee, when consideration is also given to new or other cases qualifying for inclusion within the arrangement.

Whilst on the inception of this arrangement the Committee were inclined to make no differentiation

between persons giving regular assistance in Part III Residential Accommodation and those giving similar assistance in the accommodation reserved to the Regional Hospital Board for the maintenance and treatment of chronic sick patients, the Ministry of Health advised that whilst a local authority may waive part of the payment due where services are rendered *wholly* in Part III Residential Accommodation, irrespective of whether the premises are owned by the local authority or vested in the Minister, payments cannot be waived under Section 23 (3) of the National Assistance Act, 1948, in respect of services rendered in hospital accommodation, and any payment made by a Hospital Management Committee would have to be taken into account in assessing a person's ability to pay.

In the case of establishments where there is joint user by the County Council and the Regional Hospital Board, it does seem a little unfair that there should be this discrimination between persons giving assistance in the Part III section and those giving similar services in the accommodation reserved to the Board. The inevitable result will be the engagement of extra paid assistance by way of cleaners and the like to perform such work as was previously undertaken by residents from the Part III section, which will add to the weekly maintenance costs.

The position is, however, in complete accord with the provisions of the National Assistance Act, 1948, but no doubt the point will be borne in mind by the Minister of Health if any amending legislation is introduced.

Medical Attention for Residents.

General medical supervision of the Part III Establishments continues to be undertaken by the former Institution Medical Officers, who are also Medical Officers responsible to the Regional Hospital Board for the treatment of persons in the accommodation reserved to the Board.

As was arranged in July, 1948, residents continue to have the right and freedom to select their own doctor as if they were living in their own homes, and the matter of the capitation fee payable to the doctor lies between himself and the Executive Council appointed under the National Health Service Act, 1946.

Residential Accommodation Provided by Voluntary Organisations.

Arrangements have been made with the Carlisle Diocesan Council for Social and Moral Welfare whereby, pursuant to the provisions of Section 26 (6) of the Act and the County Council's Scheme under Section 21 thereof, annual contributions are made to the Diocesan Council who will provide residential or temporary accommodation in their establishment at Coledale Hall, Carlisle, for a like purpose as that provided by the County Council under the Part III provisions of the Act.

This arrangement will be of value to the Welfare Committee in that on occasions persons concentrating on Carlisle from the Administrative County, and for whom the County Council is under a statutory obligation to provide accommodation, may, in cases of necessity, be provided with such accommodation by the Diocesan Council. The arrangement will be reviewed in 1951 on the basis of records kept by the Diocesan Council of County cases received into Coledale Hall, Carlisle.

Welfare of Old People in General—Voluntary Effort.

Whilst practically all old people in the country are now assured of a monetary income, it would be a mistake to suggest that old age pensions and supplementations thereof by way of National Assistance grants have solved the problem of the aged. The National Assistance Act envisages not merely a service limited to defined statutory provisions for the aged poor, but a wide field of welfare services for the aged as a whole, and where, concurrently with the statutory provisions, voluntary effort and services of a more personal kind could be provided by workers actuated by a spirit of good neighbourliness. There are many ways of brightening the lives of old people who still prefer to live in their own homes, but who cannot do so in reasonable comfort and happiness without help and interest from outside. One may particularly stress the great value of personal visiting, which should be regular and frequent, as a means of lessening that terrible sense of loneliness often felt by many old people. Other avenues of service are "Meals on Wheels," "Organisation of Clubs," and so on.

The Welfare Committee have already decided to exercise the powers conferred by Section 31 of the Act to make contributions to Voluntary Organisations providing recreation and/or meals for old people.

Even though the actual provision of such services as have been mentioned is not a statutory duty of Local Authorities—amending legislation would be necessary to make it so—the need for such services does nevertheless exist, and on the initiative of the National Old People's Welfare Committee (in association with the National Council of Social Service) a Cumberland Old People's Welfare Committee (consisting of representatives of Local Authorities, Voluntary Organisations, and other interested bodies and parties) has been established in an effort to promote the general good of old people in the County, and the introduction of personal services of the kind mentioned. Local Committees are now in course of being established in various areas in the County, and the Welfare Committee will not only watch their progress with the greatest interest, but will undoubtedly seek to encourage such Committees in their work of providing services of a more personal kind than those covered by the existing statutory provision and thereby add materially to the comfort and happiness of people in their old age.

In a further endeavour to assist in the organisation and stimulation of voluntary effort, the Welfare Committee is seeking the co-operation of the various local authorities (through their Health Visitors, Housing Managers, &c.), and the Press, with a view to information being received in, or passed to, the Welfare Department whenever it appears that some branch of the health or welfare services should be brought into action, thereby enabling the specific measure of such services as are necessary to be ascertained and the appropriate machinery set in motion with a view to the need being met either by the statutory authority or voluntary organisation as the case may be.

Temporary Accommodation.

The County Council is under a duty to provide temporary accommodation for persons who are in urgent need thereof, being a need arising in circumstances which could not reasonably have been foreseen, or in such other circumstances as the Council may in any particular case determine.

This provision is not for dealing with the inadequately housed or persons without a settled way of living. It is primarily intended to cover persons temporarily without accommodation as a result of such circumstances as fire, flood, or eviction which could not have been foreseen.

During the year ended 31st December, 1949, 30 cases (representing 17 men, 14 women, and 25 children) were provided with temporary accommodation due to evictions from houses or rooms, or inability to find suitable lodgings, &c., the highest number maintained in any one week being 14 persons (2 men, 2 women, and 10 children). The 30 cases consisted of 17 family units —4 units of husband, wife and child/ren, 13 units of mother and child/ren, and 13 men, including 4 E.V.W.'s.

During the period 1st January to 30th June, 1950 (six months) 24 cases (representing 14 men, 13 women, and 20 children) were provided with temporary accommodation, the highest number maintained in any one week being 23 persons (5 men, 4 women, and 14 children). Included in the 14 children were 5 Children Act cases temporarily maintained in the Nursery at Meadow View House, Whitehaven, due to the absence of vacancies in the Nursery and Children's Homes managed by the Children's Committee under the provisions of the Children Act, 1948.

Until such time as the Committee are able to provide a separate hostel or other premises for use as temporary accommodation, the administrative difficulties already experienced by having to accommodate evicted families and especially women and children in the existing Part III Establishments at Penrith, Wigton, and Whitehaven, are bound to increase rather than diminish, and especially so if, as has been the case in some counties, local housing authorities, after evicting tenants from Council houses, expect the County Council to provide temporary accommodation for such families. Any such expectation would seem to be quite contrary to what was intended by the Act, as housing authorities would have ample notice of the intended eviction of the tenants where Council houses were involved. On this latter issue the Ministry of Health

in 1949 advised a County Borough Council that the responsibility for re-housing homeless families rests with the Housing Committee except insofar as the need for temporary accommodation arose in circumstances which could not have been foreseen. Only in the latter case would it be for the Welfare Committee to provide temporary accommodation.

Whilst the position is as stated, the application thereof in principle is bound to be difficult in that it is not seen how housing authorities would provide accommodation in another Council house for a family evicted from a Council house, or provide housing accommodation for persons evicted from other than Council houses, in view of the long list of persons on the Authorities' waiting lists for Council houses.

Whilst it should not be the general practice to break up a family, the former Public Assistance Institutions, which at present are the only establishments providing residential accommodation, give no facilities for a family to live together as a unit, and this means that children have to be housed in the Nursery (where one is provided) whilst the parents are accommodated in the male and/or female sections of the establishment, thereby separating members of a family. Apart from the fact that children should not be maintained in general institutions, which provide for the maintenance of old and infirm adults in need of care and attention, the present arrangement for their temporary accommodation produces innumerable difficulties and it may well be, pending the provision of suitable accommodation where families could be housed together as individual units, that the Children's Committee may have to be asked to provide for children in need of temporary accommodation until such time as their parent(s) can make other provision.

The general problem of temporary accommodation is engaging the attention of the County Councils' Association with a view to obtaining for the country as a whole, agreement upon principles which should guide welfare and housing authorities in dealing with what is a difficult problem at any time, and almost impossible of solution during a housing shortage such as is now being experienced.

Welfare Services for the Blind.

(a) General Welfare of the Blind.

Whilst the Council's scheme for carrying out their functions under Section 29 of the Act, came into operation on the 14th April, 1949, the Welfare Committee decided that the agency arrangements then existing with the Cumberland and Westmorland Home and Workshops for the Blind, and the Barrow, Furness and Westmorland Society for the Blind should be continued until it was determined to what extent the functions under Section 29 should be discharged directly by the Welfare Committee. Accordingly the agency arrangements with the two voluntary organisations were extended from time to time to the 30th June, 1950.

As the result of conferences with representatives of the Carlisle City Council and the Cumberland and Westmorland Home and Workshops for the Blind, arranged to discuss the workshop and welfare services as then in operation, and the development and expansion of those services preparatory to further consideration being given to the question as to what extent, if at all, the functions under Section 29 might be discharged directly by the Welfare Committee as from the 30th June, 1950 (the date to which the agency arrangements had been tentatively extended), and of any variations required under any agency arrangements which may be approved from that date, it was felt that the service in several respects was not as efficient as it should be and that steps must be taken substantially to improve it and bring up the general level of administration.

It was accordingly decided that the present arrangement whereby the Cumberland and Westmorland Home and Workshops for the Blind act as agents of the County Council in the discharge of the Council's functions for promoting the welfare of blind persons resident in the major portion of the Administrative County, be extended for a further period to 31st December, 1951, in order to afford the Workshop Committee an opportunity of putting into effect a re-organised and expanded service of welfare arrangements. Further, that the Special Sub-Committee which had considered the arrangements should remain in being as a link between the Committee of the Workshops and the Welfare Committee to discuss the implementation of an

improved service to consider quarterly reports on the administration and the re-organisation and expansion of the service, and to confer on any issues of special reference arising out of the reports, or otherwise appertaining to the service.

(b) Statistics.

The following summary shows the number registered with the Council of blind persons of each sex, by age groups so far as is known, and the total number so registered of blind persons ordinarily resident in the area of the County Council on the 31st March, 1950:—

Age Group.	Men.	Women.	Total.
0—1	—	—	—
1—5	—	—	—
5—16	3	1	4
16—21	2	4	6
21—40	19	12	31
40—50	23	20	43
50—65	40	45	85
65—70	25	20	45
70 + ...	87	84	171
	199	186	385

(c) Workshop Employment.

The types of employment and the number of blind persons on the 31st March, 1950 (both men and women) provided with employment of each type were as follows:—

Trade.	Men.	Women.	Total.
Firewood Department ...	2	—	2
Bed and Mattress Making	2	—	2
Bedding Labourers ...	2	—	2
Brush Making	2	—	2
Basket Making	2	—	2
Upholstery	1	—	1
Piano Tuning	1	—	1
Machine Knitters ...	—	3	3
Re-seating Chairs (in cane). ...	—	1	1
	—	—	—
	12	4	16

(d) Home Employment.

On the 31st March, 1950, there were 7 blind persons in the home workers scheme employed in the following occupations:—

Occupation.	Men.	Women.	Total.
Braille Coypist ...	—	2	2
Piana Tuning ...	2	—	2
Farming	1	—	1
Basket Making ...	1	—	1
Boot Repairing ...	1	—	1
	5	2	7

(e) Home Teaching and Visiting Services.

Since the last report the home teaching and visiting service has been augmented by the addition to the staff of a further qualified home teacher. There are now 4 home teachers, 3 qualified and 1 unqualified, on the staff of the Cumberland and Westmorland Home and Workshops for the Blind, who cover the Administrative County to as far south as Egremont, whilst the home teacher employed by the Barrow, Furness, and Westmorland Society for the Blind covers the southern part of the county, which in the main consists of the Rural District of Millom.

(f) Hostel and Workshop Facilities in Carlisle.

Before the outbreak of World War II it was generally agreed by the County and Carlisle City Councils and the Committee of the Workshops for the Blind that the then existing workshop premises and hostel facilities in Carlisle were both inadequate and generally unsuitable. The two Local Authorities purchased jointly a mansion house and buildings standing in about 6 acres of land, and known as Petteril Bank House, Carlisle, for conversion into new workshops and a hostel. On account of the war, the scheme had to be postponed, and the mansion was used temporarily as a hostel for evacuees. The mension, outbuildings, and land are now in the occupation of the Workshops Committee acting as agents to the two Local Authorities, and schemes are in course of consideration jointly with the Government Departments concerned for the full development and use of the estate for the purpose for which it was originally acquired.

(g) Survey of Register of Blind Persons.

At the request of the Welfare Committee, the Regional Supervisor for the North Regional Association for the Blind made a survey of the County Register of Blind Persons, with particular reference to those blind persons who were included in the 16/65 year age groups with a view to ascertaining the potential employment figure. Statistics as at 28th February, 1950, showed the number of blind persons between the age groups 16/65 years as follows:—

Age Group.	Men.	Women.	Total.
16—21	3	2	5
21—40	21	13	34
40—50	20	18	38
50—65	42	39	81
	86	72	158

Excluding those blind persons already in training and/or employment, the total number of blind persons concerned was reduced to 115.

During the course of the survey, and arising out of a detailed examination of a fairly large number of cases as a basis for discussion, it was found that in view of the circumstances and conditions associated with a number of blind persons (i.e., the necessity for continuance of eye and other forms of treatment, deafness, immobility, temperament, private and domestic reasons, &c.) such persons should be eliminated from the list of probables for training and employment. Some cases were, however, recommended for

(a) Workshop employment.
(b) Employment in open industry.
(c) Training, and/or
(d) Courses of Social and/or Industrial Rehabilitation;

and appropriate action was taken thereon.

In the course of the survey two interesting observations were made by the Regional Supervisor which seemed to justify the effort which had been made. These were

(1) Some of those interviewed showed a very definite interest in the possibilities of employment, and any unnecessary delay in ascertaining their prospects may cause them to feel frustrated and they will become unsettled.

(2) It is my opinion that the interview did much to improve the outlook of the blind and in a good many cases there appeared to be a definite keenness and a desire to do something useful.

Arising out of the survey the Welfare Committee decided that a Consultative Panel consisting of the County Welfare Officer, the Supervisor for the North Regional Association for the Blind, the Local Disablement Resettlement Officer of the Ministry of Labour and National Service, the Blind Placement Officer and the Secretary/Manager of the Workshops for the Blind be established for the purpose of

(a) Reviewing from time to time the Register of Blind Persons;

(b) Interviewing such unemployed blind persons as may be considered suitable for and/or desiring training or employment; and

(c) Considering the possibilities of extending the Home Workers Scheme to those persons who, though fit for training and/or sheltered employment, live too far away from the Workshops and are not desirous of residing in the hostel at Petteril Bank, Carlisle.

(h) Minimum Wage Schemes (Workshop Employees).

By agreement with the Carlisle City Council and the Committee of the Workshops for the Blind, an amended scheme of (a) conditions of employment, (b) minimum wages, (c) augmentations and bonuses, and (d) provision for sickness, unemployment and holidays has been adopted for application to blind workers employed in the Carlisle Workshops for the Blind. One may, however, express some concern at the apparent lack of uniformity throughout the country in the method of augmentation of earnings of blind persons employed in workshops and of blind home workers, and it is of interest to note that the County Councils Associations are again considering, in conjunction with the Ministry of Labour and the National League for the Blind, proposals for the establishment of machinery to recommend a national basis upon which augmentation rates might be paid to blind workers in the workshops.

Welfare of the Deaf and Dumb and Hard of Hearing.

Section of 29 of the Act contemplates that local authorities will provide for the deaf and/or dumb welfare services similar in character to those at present provided for blind persons, and paragraph 16 of Part II of the Council's Scheme under Sections 29 and 30 of the Act provides that in making a survey of the needs of their area for the purpose of the provision of such services, regard shall be had to the welfare services already available, and to discussions which have been opened up with voluntary organisations concerned.

The Carlisle Diocesan Association for the Deaf and Dumb (affiliated to the National Institute for the Deaf) operates throughout the geographical counties of Cumberland and Westmorland, the Furness area of the Lancashire County Council and in the area of the County Borough of Barrow-in-Furness, and is the only Association in that area providing a welfare service for deaf and dumb persons of all denominations. The Association has Institutes in Carlisle and Barrow, with centres in Kendal and Workington, where the deaf and dumb may enjoy special services by means of finger spelling and gesture.

In the whole area on the 31st March, 1950, there were 248 deaf and dumb persons on the register, distributed and classified as follows:—

Category.	Area. Cumb. C.C.	Westd. C.C.	Lancs. C.C. (Furness Area).	Barrow-in-Furness C.B.C.	Carlisle C.B.C.	Total
School age or under	16	3	1	5	9	34
In Institutions	2	—	1	1	1	5
In Mental Hospitals ...	5	—	—	—	2	7
In full-time employment ...	64	9	9	17	20	119
Married women at home ...	15	4	2	6	11	38
Single women at home ...	5	2	1	3	—	11
Unemployable by reason of age	3	2	1	5	1	12
Unemployable by reason of infirmity	5	2	—	3	3	13
Incapacitated for over whole of year	1	—	—	—	—	1
Unemployed	3	—	—	1	1	5
Private means	—	—	—	—	3	3
Total ...	119	22	15	41	51	248

Whilst the Minister of Health has directed that Local Authorities shall be under a duty to exercise their powers under Section 29 in relation to blind persons ordinarily resident in their areas, no similar direction has up to the present been given in regard to the deaf and dumb and other classes. In June, 1948, the Minister did suggest that a careful survey of the needs of the area and of the services at present available must precede any attempt by a local authority to exercise their powers under Section 29 in relation to the classes mentioned or to formulate schemes for that purpose and that the authorities would be well advised to open discussions immediately with all other organisations, official and voluntary actively concerned. In an effort to secure uniformity throughout the country in the development of welfare services, the Minister appointed an Advisory Council to advise him on questions relating to the welfare of persons to whom Section 29 applies, and hoped to give local authorities further suggestions for extending their approved welfare scheme for the blind to other handicapped persons.

As it appeared to the Welfare Committee that the Minister would wish local authorities to make progress in the matter of the welfare services in question, notwithstanding the complex nature of the problem and the fact that no suggestions, advice or guidance had yet been given negotiations were opened with the Lancashire and Westmorland County Councils and the Barrow-in-Furness and Carlisle County Borough Councils with a view to the Carlisle Diocesan Association acting as agents for the authorities mentioned, for the purpose of the exercise of the authorities' powers under Section 29 (1) of the Act in the provision of welfare services for the deaf and dumb, but not the " hard of hearing," in that it was understood a separate scheme or service might probably be necessary for the latter group.

In the interests of securing a uniform service throughout the area covered by the Diocesan Association who were desirous of placing their services at the disposal of the local authorities by acting as their agents, general agreement was reached by the officers participating in the negotiations that as from the 1st April, 1950, the Association should continue to provide welfare services for deaf and dumb residents within

the area covered by the Association (excluding for the time being any application of those services to the "hard of hearing"), and take steps to develop and expand those services on agreed lines without at this stage the submission of any detailed scheme for the approval of the Minister of Health.

In regard to finance, due provision was made for payments by the local authorities concerned to meet the estimated deficit of the Diocesan Association for 1950-51 on the basis and to the extent that the number of registered deaf and dumb persons over 16 years of age in their respective areas on the 1st April, 1950, bears to the total number of deaf and dumb persons over 16 years of age on the register of the Association. Provisions was also made for local authority representation on the Committee of the Association and for a review of the position before the end of 1950.

With the exception of the Westmorland County Council from whom, at the time of the writing of this report, a decision is still awaited, the agreements reached have been ratified by the Local Authorities concerned.

Pending any instructions or guidance which may be issued by the Minister of Health on the advice of his Advisory Council, it is felt that the interim agreement will not only ensure continuity and expansion of the welfare services as in existence prior to the 5th July, 1948, but provide a sound basis on which to model a permanent scheme for the future.

North Regional Association for the Deaf.

The Welfare Committee have decided to give official recognition to the above Association, whose main object is to act as an advisory and consultative body and to work in conjunction with the National Institute for the Deaf in promoting the welfare of the deaf and dumb, the deaf blind, the deafened and the "hard of hearing." The Association covers the seven Northern counties, viz.: — Cumberland, Durham, Northumberland, Westmorland, Lancashire, Cheshire, and Yorkshire.

Handicapped Classes (Other than Blind, Deaf and Dumb).

No definite scheme has yet been considered for the provision of appropriate welfare services for the

residual group of handicapped persons and, pending any advice or guidance which may be given by the Minister of Health on this issue, and which it is hoped will clarify the position, individual needs will be considered and dealt with by the Welfare Committee as and when cases arise.

Reception Centres.

Persons Without a Settled Way of Living.

The Act imposes a duty on the National Assistance Board to encourage persons without a settled way of living to lead a more settled life, and to provide and maintain Reception Centres at which temporary board and lodging is made available to such persons, but that duty is still undertaken on behalf of the Board by County and County Borough Councils.

Whilst the Board are alive to the difficulties and problems confronting them, it is understood that due to the economic position of the country there is no immediate prospect of Local Authorities being relieved of the duty to maintain Reception Centres.

In the Administrative County there is now only one Reception Centre which is at Station View House, Penrith, an establishment providing Part III accommodation and treatment for a certain number of chronic sick patients. The centre at Meadow View House, Whitehaven, was closed on the 1st March, 1949, and has not been re-opened, although there is an understanding with the Board that if wayfarers turn up at Whitehaven and it is not possible to get them by public transport to the nearest open centre, they are given accommodation for the night.

The following table shows the number of wayfarers provided with temporary board and lodging, and the extent to which the number has gradually increased quarter by quarter:—

	Penrith.				Whitehaven.			
Quarter ended.	M.	W.	Ch.	Total.	M.	W.	Ch.	Total.
30/9/48	221	6	—	227	48	2	—	50
31/12/48	255	16	—	271	60	4	—	64
31/3/49	336	6	—	342	44	—	—	44
30/6/49	398	17	—	415	24	3	4	31
30/9/49	453	16	—	469	17	—	—	17
31/12/49	456	24	—	480	7	—	—	7
31/3/50	515	17	4	536	6	—	—	6
30/6/50	627	28	—	655	9	—	—	9

Wayfarers considered suitable and physically capable of work are referred to the Ministry of Labour and National Service, but very few indeed accept, or are placed in, employment. Those who are willing to take up work are given the opportunity of remaining in the Centre—agreeing to make certain payments for their maintenance—for a limited time in order to give them an opportunity of finding lodgings. During the year ended 31st December, 1949, 18 men and 1 woman were placed in employment. Invariably, however, the employment is of very short duration and it is doubtful if the effort is worth while.

Whilst elderly or incapacitated wayfarers are encouraged to leave the roads and settle down permanently in Part III Accommodation, the response is discouraging. During the twelve months to 31st December, 1949, 5 men were transferred to the hospital section of the establishment at Penrith for necessary treatment, and 3 elderly persons expressed their willingness to settle down in Part III Accommodation. Of the latter group, one remained for 3 weeks; one for 10 weeks and one for 4 months (November to March). Evidently the comfort of good accommodation, food and the many amenities provided in Part III Establishments makes little appeal against the free life of the open road. Whilst the problem of the casual or tramp did lesson itself during the war years, it would seem from the admissions at Penrith that it is now growing again and the matter of its solution seems well nigh impossible.

Very few wayfarers require medical attention, and as they generally leave the centre in the early morning following admission, no system of fixed medical examinations is possible. Minor ailments are mainly dealt with satisfactorily under the Matron's directions, but any wayfarers requiring medical advice are referred to a local doctor, usually the Medical Officer responsible for the general medical supervision of the premises. The arrangements have met with the approval of the National Assistance Board.

Whilst there is no power to compel wayfarers to remain for a second night in a reception centre, and whilst there is similarly no authority for refusing permission for such a person to stay more than one night

if he wishes to do so, it has been our practice in Cumberland to encourage wayfarers to remain in the centre over the week-end, although it would appear that such a practice did not exist at neighbouring centres, with the result that week-end admissions to Penrith are on occasions above the normal.

Casual wayfarers do present a most difficult problem, especially where accommodation has to be provided within a Part III Establishment, and unless the National Assistance Board themselves take steps to provide separate reception centres away from Part III residential establishments, more difficulties will arise if and when residential accommodation for the aged and infirm is provided in hostels, and former Public Assistance Institutions with their casual ward sections cease to exist.

General Observations.

During the past eighteen months the general day to day administrative arrangements have proceeded smoothly, and collaboration established where necessary with the various Government Departments concerned, and other sections of the County administration, where services additional to those provided under the National Assistance Act could be invoked for the benefit of individuals concerned. Much helpful advice has also been given to many persons on issues completely outside the statutory duties of the County Council.

No set pattern for a report on welfare services provided under the Act of 1948 has been laid down, and whilst it is difficult to know what to include in such a report, it is emphasized that what has been set out above must not be taken as an exhaustive survey covering the whole field of activities of the Welfare Sub-Committee. It merely touches upon some of those main features of the administration which it is thought would be a useful supplement to the County Medical Officer's Report for 1949, although certain issues therein have been brought up to date by taking them beyond that year.

In conclusion, I think it may be said that the County Council, acting through the Welfare Sub-Committee, is fully alive to its duties and powers under the Act and will, as soon as circumstances permit, implement them to the full.